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ABSTRACT

These 12 monthly newsletters from 1996 explore the many problems encountered by children and adolescents as they grow up. Regular departments in the newsletter issues include "Keep Your Eye On...," which briefly presents results of research into childhood and adolescent problems; "What's New in Research," summarizing research from recent publications and professional conferences; "Commentary," featuring editorials from various professionals working with children and adolescents; "Announcements," which lists events and conferences of interest to those working with adolescents; book reviews; and client handouts designed for use by practitioners. Major topics featured in the 1996 newsletters include: (1) Asperger's Disorder, adolescent suicide and its effect on the mental health professional, why the child protection system doesn't work, and infant mortality (January); (2) lead exposure and delinquency, effects of homelessness, reducing the trauma of divorcing parents, and taking care of the caregivers (February); (3) screening preschoolers for developmental problems, physical attractiveness stereotypes among young children, overuse of Ritalin, and the effects of growing up with violence (March); (4) infant competence, effects of family mobility, drug-exposed infants, and choosing toys (April); (5) design of youth residential care, juvenile justice, and mental health treatment and managed care (May); (6) Romanian orphans, organization of language in the brain, and juvenile justice (June); (7) "lost" (disconnected from society) youth, and violence in schools (July); (8) use of physical restraint in mental health facilities and testing for Attention Deficit Hyperactivity Disorder (ADHD)(August); (9) cocaine and drug-exposed babies, fathers and adolescent eating disorders, and violence in schools (September); (10) the meaning in babies cries, and adolescent girls in middle school (October); (11) early receptive language, eye movement desensitization and reprocessing (EMDR)(November); and (12) policy reform and family values, the Neonatal

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Behavioral Assessment Scale (NBAS) developed by T. Berry Brazelton, and protecting children in the welfare reform process (December). A year-end index to the issues in this volume facilitates searching for particular topics. (DR)

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

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ED 407 163

Professional Support

After an adolescent's suicide, who consoles the therapist?

By Brian Barr, CSW

Suicide devastates families, schools and communities. Families can turn to support groups, and many schools have a well-established process for helping students process the experience.

What, however, do we have in place for the mental health practitioner who has lost a patient to suicide? What do we have in place for the clinic or hospital when a patient commits suicide?

The answer appears to be: Little or nothing.

As a result, some very capable, sensitive practitioners are damaged because their healing needs have been left unattended.

Practitioners may move toward isolation, display a lack of vitality, waver in their professional judgments and, in general, show less confidence in voice and manner. These manifestations, if not tended to, harbor the potential for further emotional damage to the clinician. Inevitably, the clinician's practice will

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> ***We need to recognize that a significant loss has occurred for the clinician, that, as with any abrupt halt to life, there will be a period of questioning.***

Vol. 12, No. 1 January 1996

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Why the child protection system doesn't work.
See page 2

Infant mortality is down, but the gap between black infants and white infants is getting wider.
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Which depressed teens will still be depressed a year later?
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Coming Up:

Sleep — what's normal, what's not for children and teens.

This month's client handout:

Depression and substance abuse can be a lethal combination.

PS 025412

Clinical Questions

How to tell Asperger's from autism

By Edward Susman

Although first described more than half a century ago by Austrian therapist Hans Asperger, the disorder that bears his name has, until recently, been considered a variant form of autism. Asperger's Disorder is now a separate entry in DSM-IV, but researchers are only just beginning to learn about the etiology and presentation of this mystifying disorder.

"We ended up with children with seemingly average IQs who were very odd in terms of their social relatedness," says Rose Huntzinger, PhD, a neuropsychologist at Bradley Hospital, a psychiatric hospital for children and adolescents in Providence, RI.

Indeed, one of the markers of Asperger's Disorder is severely impaired social functioning.

Eleven children Huntzinger and her colleagues examined at Bradley all had difficulty relating to others; they characteristically had few or no friends. They tended to show little facial emotion, and had trouble interpreting the facial expressions of others.

Because of these characteristics, the youngsters were described as autistic for a long time. But because they had excellent verbal skills, their parents didn't accept the diagnosis, says Anne Walters, PhD, associate director of Bradley School in Middletown, RI.

"Lay people recognize that their child is really quite different from autistic children," Walters says.

Most of the parents of the Brad-

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Public Policy

APA report calls for overhaul of child protection system

A new report on child abuse and neglect released by the American Psychological Association (APA) calls for a revamping of the child protection system to de-emphasize investigation and coercive actions as the only solution.

The system needs to focus more on prevention and treatment, says the APA's "Working Group on Child Abuse and Neglect: Psychological Issues Related to Child Maltreatment," using early interventions in the community as the main resource for families to get help before a child ends up in the hospital, on the street or dead.

"Child abuse is a national epidemic," says Diane J. Willis, PhD, chair of the working group, whose report appeared in the December issue of the *Journal of Clinical Child Psychology*. "Child maltreatment is not decreasing, with over 3 million reports made to social service and law enforcement agencies in the United States. If the economy worsens and people lose their jobs, and the safety net once provided by government is gone, we are going to see an increase of child abuse and neglect."

> **'Although serious physical and sexual abuse do occur in alarming frequency, most reported cases primarily involve neglect or emotional abuse in families living in poverty and in social isolation.'**

Willis calls for more research on treatment. "Early intervention is absolutely critical and could prevent more serious cognitive and psychosocial problems," she says.

Over the past four years, members of the working group examined the current psychological research on the prevention and treatment of child abuse and neglect, as well as research on legal issues. They found that many services protect only those already in danger because of ongoing abuse but do not offer preventive assistance to those on the verge of abuse.

Among the key findings were:

- Child protection agencies are set up to intervene only *after* the abuse has occurred.
- Policies are not child-centered but system-centered. They are reactive vs. proactive, and by the time officials react, it's usually too late. Families need access to services all the time, from the beginning, and not only when someone gets arrested.
- Needed are programs that concentrate on strengthening parents' skills in coping with stressors and risk factors in order to increase family functioning and decrease the likelihood of using violence in a tense situation.
- Programs that attempt to empower children to avoid situations that might lead to sexual abuse don't work very well. Children can't be expected to know what is appropriate touching and what is not in every situation.
- Prevention efforts that encompass the individual, the family and community at large, such as home visitation, parent education and child sexual-abuse prevention programs, have proven to work better than programs that target only one risk factor or a particular family member.

"Putting the onus on the child to protect him-/herself doesn't work," the report says. "A child must first recognize that he/she is in an abusive situation, and even many adults are unclear about what constitutes sexual abuse. A child must believe that he/she can take action and know what the appropriate action is, which is a lot to ask from a 7-year-old."

"Child abuse is a preventable tragedy," says child abuse prevention expert David Wolfe, PhD, of the University of Western Ontario, "and in all likelihood, we will never have the resources to treat the problem after the fact. Prevention is a much more viable solution in the long run."

Neglect is a serious form of child abuse that needs attention, adds Barbara Bonner, PhD, director of the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center in Oklahoma City.

"There is a need for further research, especially in neglect cases," Bonner says. "The recent focus has been on child sexual abuse. We have a lot more research on sexually abused children than we do on physically abused or neglected children,"

The typical child protection case is very different from the image portrayed in the media and probably widely held among both the general public and the professions, the report says.

"Although serious physical and sexual abuse do occur in alarming frequency, most reported cases primarily involve neglect or emotional abuse in families living in poverty and in social isolation."

Willis, the group's chair, says community-based services should be targeted to at-risk families, such as first-time or adolescent parents. "By setting up community-based services in the schools — parenting classes, literacy classes, treatment classes for disturbed children or children who have been abused — you have all the essential services in one place," she says.

"Unfortunately, our present system makes us go to extremes," she continues. "We either remove children too quickly and not provide enough services for the family, or the children stay and then suffer serious brain damage from physical abuse or die. Removing a child from a home works only when there are realistic services to take the place of the home."

According to the task force report, the current system of mandatory reporting of possible maltreatment of children to social service and law enforcement agencies is too unreliable and ineffective in protecting children. Less than one quarter of mental health professionals, says the report, believe that children actually benefit from their reports to child welfare authorities. Furthermore, fewer than half of reported cases are substantiated.

"The problem is that most of the resources are allocated to investigation, which by itself does not increase the safety of children," says Gary B. Melton, PhD, of the University of South Carolina and an expert on the legal issues of child maltreatment. "We need a system that promotes prevention and treatment."

Melton adds that coercive interventions, while sometimes necessary, aren't the best solution. "Kids might be better protected if the legal system were removed from child protection work altogether," he says. "Unfortunately, though, if we did that, some kids would be left in truly egregious situations. The problem is to redesign the system in such a way that the use of coercive sanctions is a last resort."

One direction that looks promising, according to the working group report, is to provide alternatives to mandated investigation, which only supports responses to allegations of child abuse, rather than needs for help. Many employees at child protection services spend most of their time gathering evidence and preparing for court, Melton says.

The working group also found that 40 percent of families in which child abuse or neglect is actually substantiated receive no services at all.

"Even when they have time to provide services, their ability to help may be compromised by their law enforcement role," Melton says. ■

Statistics

Infant mortality lowest ever, but racial gap widens

In 1994, infant mortality dropped to the lowest rate ever recorded in the United States, according to an annual summary of statistics. The trend is related to declines in respiratory distress and deaths from sudden infant death syndrome (SIDS), according to the summary, which provides a "snapshot" of U.S. births, marital status and deaths and is based on data from the National Center for Health Statistics.

Despite the overall fall in infant mortality rates, the gap between black and white newborns is increasing. While there is no adequate explanation, racial differences in the infant mortality rate remain a major national concern.

"We have a lot of work to do in this area," says the article's lead author, Bernard Guyer, MD, MPH, of Johns Hopkins School of Hygiene and Public Health.

The summary also suggests that the proportion of teens who are sexually active may have leveled off, especially among younger teens. According to the report, both the teen birth and abortion rates have fallen in recent years, with greater declines in the abortion rate.

Other summary highlights:

- In 1994, an estimated 31,400 infant deaths were reported in the United States. Washington state reported the fewest infant deaths (5.4 infant deaths per 1,000 live births), while the District of Columbia had the highest (20.1 infant deaths per 1,000 live births).
- Marriages and divorces increased by 1 percent between 1993 and 1994, the first rise in the numbers since 1990.
- The number of births fell below 4 million in 1994, for the first time since 1989.
- Use of prenatal services improved for the second consecutive year, following more than a decade of little change.

The report concludes that the number of children under age 18 in the United States is expected to increase by 10 million to close to 78 million by the year 2020.

"The increasing ethnic and racial diversity of the child population has important implications for the health of children, especially relative to the availability and appropriateness of health services for them," the report says. ■

"Annual summary of vital statistics — 1994," Bernard Guyer, et al., *Pediatrics*, 96(6):1029-1039, 1995.

After suicide

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be affected by his or her diminished zest for the work.

Working with a potential suicide is extremely demanding. The patient's depth of despair often presents itself as a raging hostility, a bottomless vessel of unmet needs and a chronic voice of negativity. Beyond the clinical presentation, the therapist assumes care for a life-or-death scenario.

The heavy responsibility of these cases makes therapists reluctant to take them on. I have frequently been unsuccessful in my attempts to connect a suicidal person with a therapist. When I ask why, therapists' responses clearly suggest: "Why take on this population when others less needy and less potentially shattering to our world of helping others are available?"

Part of the reason practitioners shy away from the suicidal is because we've neglected to recognize the burden of caring for these patients and failed to give them the necessary supports. In this day and age of stated outcomes, clinicians hesitate to engage with a client whose purposes imply potential suicide. The absorption of experiencing a sense of profound failure leads even the most compassionate to question the process.

When therapists are informed that a client has taken his or her own life, they, of course, feel the loss, but they also must deal with the fear of being held responsible. They must confront the possibility of a law suit.

Therapists listen to distraught parents, relatives and media inquiries. Their professional reputations may be questioned, which can have a far-reaching impact on their practice.

We need to alter the course of our professional response to our colleagues who dare work with the suicidal. And we must demonstrate that caring by adjusting the system to include consideration for those working with clients at maximum risk.

We need to recognize that the therapist might have been wounded, that a significant loss has occurred for the clinician, that — as with any abrupt halt to life — there will be a period of questioning.

We need to build a network of support for those who work with this at-risk population. Responsibility must be shared and given context in the overall system of providing community health care.

Time needs to be set aside for group sharing and learning. A facility, a professional organization or another reputable source can appropriately take leadership.

A mobile team should be on call for therapists who lose patients. They require a forum for sharing as well as practical guidance in preparing themselves to handle fallout from a suicide on their caseload. Therapists cannot be expected to handle their own grieving and subsequent healing.

A response team can be recruited from among those who have lived with the effects of a loss by suicide. I haven't found too many unwilling to relate their private, often anguished experience when their pain and distress have been acknowledged.

As part of their standard method of promoting professional responsibilities, all facilities offering service to the suicidal should have an ongoing group for therapists working with the suicidal, and a standby group ready to engage with the therapist who has lost someone to suicide. ■

Brian Barr is director of clinical and community services at La Salle School in Albany, NY. The school provides a residential and day service program for adolescents who have had difficulty at home, in school or the community. Mr. Barr has been active in the field of suicide since 1984, when he lost his 18-year-old son, Kevin, to suicide. He received the 1993 Samaritan of the Year Award for his volunteer work.

Announcements

Trauma experts to speak at Georgetown conference

Georgetown University Medical Center's second annual conference on "Trauma, Loss and Dissociation: Foundations of 21st-Century Traumatology," will meet Feb. 29-March 4 at the Radisson Park Plaza Hotel in Alexandria, VA. Speakers will highlight the latest scientific advances for practical application by clinicians. Look for the flyer in this issue of *The Brown University Child and Adolescent Behavior Letter*. **Call** (800) 844-2789 or (202) 265-4704; **fax** (202) 265-265-4714; or **e-mail** cgbutler@aol.com.

Clinics needed to host public anxiety screenings

Freedom from Fear, which is organizing the third annual National Anxiety Disorders Screening Day on May 1, is seeking screening sites. Mental health professionals are needed to conduct free, anonymous screenings, as well as provide educational materials and referral sources. All the necessary screening questionnaires and consumer educational materials will be provided. **Registration deadline:** March 8. **Fee:** $100. **Call** Jeanine Christiana at (718) 351-1717, or **fax** (718) 667-8893.

Family researchers to meet at summer institute

The Family Research Consortium will accept a limited number of both junior and senior researchers to make presentations at its summer institute, to be held June 20-23 at the Hotel Del Coronado in San Diego. The theme of the 1996 institute is "Continuity and Change: Family Structure and Processes." **Application deadline:** March 15. **Call** Kathy Meese at (919) 966-3318; **fax** (919) 966-7532; or **e-mail** meese.fpg@mhs.unc.edu.

Depression and substance use can be a lethal combination for teens

The teen years are a period of turmoil for just about everyone. Learning new social roles, developing new relationships, getting used to bodily changes, making decisions about the future — all of these things can be overwhelming. With neither the comforting dependence of childhood nor the full-fledged membership in adulthood, teens often feel as if they were floating in limbo — isolated, confused, scared, and alone.

It is not surprising then, that depression is a common illness among adolescents. The feelings of helplessness and hopelessness that accompany depression can fuel a downward spiral of health and self-esteem, which can have potentially deadly results: In one study of teenage suicides, 60 to 70 percent of the teens had been diagnosed with a depressive illness prior to their deaths. An alarming 90 percent of the sample had some form of psychiatric diagnosis — depression, mood disorder, or substance abuse disorder.

According to David Shaffer, M.D., adolescent depression often is complicated further by substance use problems. In one study, nearly 45 percent of the teens who had committed suicide in a two-year period, had been abusing alcohol at the time of their deaths.

What to look for

Teens who are contemplating suicide often show symptoms of depression and/or substance use. The following symptoms typically indicate a problem:

⇒ sleep disturbances — fatigue, frequent napping, early waking;

⇒ change in appetite — sudden noticeable weight loss or gain;

⇒ restlessness, inability to concentrate;

⇒ dramatic mood changes;

⇒ feelings of hopelessness, helplessness, despair; and

⇒ withdrawal from friends and previously enjoyed activities.

Teens who are depressed and abuse substances are at high risk for attempting suicide. If you think that your teen might be at risk, contact a professional immediately. Early intervention can prevent suicide attempts, and your teen can receive treatment for depression and for substance use.

Other risk factors

Young people who have attempted suicide in the past or who talk about suicide are at greater risk for future attempts. Listen for hints like, "I'd be better off dead," or "I won't be a problem for you much longer," or "Nothing matters; it's no use."

Adolescents who consider suicide generally feel alone, hopeless, and rejected. They are more vulnerable to having these feelings if they have been abused, feel that they have been humiliated recently in front of family or friends, or have chaotic, disorganized family lives.

Teenagers who are planning to commit suicide might "clean house" by giving away their favorite possessions, cleaning their rooms, or throwing things away. They also may become suddenly cheerful after a period of depression, because they think that they have found a solution by deciding to commit suicide.

One of the most dangerous times of a teen's life is when he or she has suffered a loss or humiliation of some kind — loss of self-esteem by doing poorly on an important test, breakup with a boyfriend or girlfriend, parents' divorce, for example.

Continued on next page . . .

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What you can do

Most people who are depressed or who are thinking about suicide don't or won't talk about how they're feeling. They deny their emotions or think that talking about it will be a burden on others because no one cares. Or they are afraid other people will criticize or make fun of them.

If your child brings up the subject of suicide with you, take it seriously and take some time to talk about it.

Reassure your child that he or she has someone to turn to. Remind the child of all the people who care about him or her — friends, family members, school counselors, physicians, or teachers.

Don't lecture or point out all the reasons your child has to live. Instead, listen and reassure your child that the depression and suicidal tendencies can be treated.

Get help immediately. Don't wait for the symptoms to worsen. Contact one of the resources listed here, or check the yellow pages for the local chapter of the American Psychiatric Association. Don't attempt to solve the problem alone, and don't assume that the child is not serious. Any mention of suicide, even in what appears to be jest, should be considered seriously.

Source: "Let's Talk Facts about Teen Suicide," a publication of the American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005

Other resources:

American Association of Suicidology
2459 South Ash Street
Denver, CO 80222

National Committee
of Youth Suicide Prevention
666 Fifth Avenue, 13th Floor
New York, NY 10103
(212) 957-9292

The Brown University Child and Adolescent Behavior Letter

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Prepared by Mary-Kim Arnold, editorial assistant.

Which teens will still be depressed a year later?

Depressed adolescents who are less positively involved with their fathers and less responsive to their mothers' discipline were more likely to still be depressed a year later, compared with other depressed teens, according to a new study. In addition, those whose depression persisted were older and more likely to have substance use or anxiety disorders. Of the 67 13- to 19-year-olds with major depression who began the study, two-thirds had remitted a year later. The findings demonstrate the importance of family relationships in the course of major depression, but the exact mechanisms at work are still unspecified. One theory is that positive involvement with parents may act as a buffer against the stressors that precipitate adolescent depression. It may also be that harshly punitive parenting may lead to depression, directly or indirectly. While substance abuse predicted the persistence of depression regardless of other variables, the predictive power of comorbid anxiety disorder depended on the effects of age and comorbid substance use disorder. This finding suggests that there may be a subgroup of younger, non-externalizing adolescents for whom anxiety exerts a negative influence on the course of depression. Another interesting finding: Adolescents and parents didn't seem to agree on whether depressive symptoms persisted. While one-third of the adolescents reported persistent depression a year later, only 15 percent of the adolescents were still depressed according to their parents.

"Predicting the one-year course of adolescent major depression," Mark Sanford, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(12):1618-1628, 1995. For reprints, write to Dr. Sanford, Department of Psychiatry, McMaster University, PO Box 2000, Station A, Hamilton, Ontario, Canada L8N 3Z5.

Day care safer than home for very young children

Day care centers seem to be safer than home care for children in the first two years of life, but are about equal to in-home child care for 3- to 6-year-olds, a new study finds. Researchers analyzed 770 injuries to 9,454 children ages 6 months to 6 years in day care centers, homes and other settings in Stavanger, Norway. According to the study, the rate and severity of injuries in both day care and home settings were similar for 3- to 6-year-olds — the age of most children attending day care centers. Falls accounted for the most injuries: 65 percent in day care and 60 percent in home settings. For children ages 6 months to 2 years, though, day care centers had significantly lower risk than home child care. For example, falls were twice as high at home.

"How safe are day care centers? Day care versus home injuries among children in Norway," Branko Kopjar and Thomas Wickizer, *Pediatrics*, 97(1):43-47, 1996. For reprints, write to Dr. Kopjar, National Institute of Public Health, Department of Population Health Sciences, Geitmyrsveien 75, 0462 Oslo, Norway.

Growth-deficient children have behavioral problems

A new study confirms previous work that identifies growth-deficient children as behaviorally aberrant. But contrary to long-held assumptions, mothers of these children reported about the same overall stress levels as mothers of comparison children — with the exception of increased amounts of child-related stress and social isolation. Growth deficiency, which is related to poverty-induced malnutrition, is defined as weight persistently below the fifth percentile based on National Center for Health Statistics (NCHS) growth chart, or less than 80 percent of average for age, or a drop in weight across two standard deviations of the growth chart without a constitutional basis over a six-month period. Forty-eight growth-deficient children and 50 matched comparison children received complete medical evaluation, a developmental screening test and laboratory analyses of lead and hemoglobin levels. Parents completed the Parenting Stress Index (PSI), a 100-item questionnaire that measures parental and child characteristics. While PSI scores showed no significant difference in overall stress, mothers of growth-deficient children described their children as inflexible and difficult to console.

"Parental stress and growth outcome in growth-deficient children," William G. Bithoney, et al., *Pediatrics*, 96:707-711, 1995. For reprints, write to Dr. Bithoney, General Pediatrics, Children's Hospital/CCHP, 300 Longwood Ave., Boston, MA 02115.

Children don't follow advice in thwarting attackers

Most children who are assaulted get angry and fight back against their attackers — a strategy that isn't recommended by most victimization prevention educators, who advise screaming, threatening to tell or running away. However, the national telephone survey of 1,011 10- to 16-year-olds found substantial variability in the use of self-protection strategies. The non-aggressive strategies advocated by prevention educators were more common among girls, younger children, those advised by parents to avoid violent confrontations, and those threatened by adults. More aggressive strategies, involving threats of harm to the perpetrator and fighting back, were used by boys, especially teenage boys, and those either threatened by peers or advised by a parent to fight in the face of an attack.

"What works for children in resisting assaults?" Nancy L. Asdigian and David Finkelhor, *Journal of Interpersonal Violence*, 10(4):402-418, 1995. For reprints, write to the authors at the Family Research Laboratory, 126 Horton Social Science Center, University of New Hampshire, Durham, NH 03824.

Asperger's

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ley children had already found out that their children had Asperger's and were seeking a second opinion. They had received previous diagnoses of attention-deficit hyperactivity disorder (ADHD).

The 10 boys and one girl ranged in age from 6 years, 2 months, to 17 years, 4 months. None was classified as mentally retarded, and their full-scale IQ scores ranged from 77 to 133.

Eight lived at home with both parents, and the other three lived with at least one biological parent. Only one parent reported any fetal distress during delivery.

The child with Asperger's Disorder is described as a 'little professor,' spewing out facts and figures with the air of an expert in the field.

The typical Asperger's Disorder child, Walters says, is characterized by lack of peer relationships and poor social functioning. He or she will often violate the privacy of others, frequently by touching improperly.

But the salient feature of the disorder is the child's preoccupation with a favorite subject — such as dinosaurs, genealogy and sometimes violent and sexual themes — and will talk about it, often in a monotone or in strangely affected speech patterns, at great length and at inappropriate times. Nor will the child detect, understand or heed attempts by others to stop. He or she will often avoid making eye contact with others, but will have a vast, detailed interest in the environment. The child can memorize numerous facts and understand what they mean.

In fact, the child with Asperger's Disorder is described as a "little professor," spewing out facts and figures with the air of an expert in the field.

In one instance, two children at Bradley were being interviewed back to back. The first child had drawn a picture of the Loch Ness monster, which was still on the board when the second child came in, asked what it was and proceeded to explain why the rendition was improper. He then laid out all the scientific evidence proving his case, despite the fact that there isn't any such evidence.

While the behavior of Asperger children can be amusing to adults, "these children are teased mercilessly at school," says Karen Cammuso, PhD, director of the outpatient developmental disabilities unit at Bradley Hospital. Other children become so unmanageable at school that they are referred to special programs.

Parents, teachers and clinicians are concerned that as the children grow up, they may become psychotic or depressed because they have difficulty in making and maintaining relationships. Children don't "grow out" of Asperger's, and their social and behavioral problems are lifelong.

The children are also somewhat clumsy, Huntzinger says, and tests indicate the possibility of a neurologic deficit that could account for the fact that none of the children in the study would be considered athletic.

"These are the kids who are first to get beaned in a game of dodge ball in gym class," she says.

Cammuso tried to determine if there was a genetic link, and found, in interviews with parents, a number of psychiatric disorders in previous generations. Six children had parents or grandparents with depression-like conditions; six were symptomatic of affective disorders; six had relatives with Asperger characteristics.

In fact, as Cammuso interviewed the children's parents, she found that six of the fathers and three of the mothers themselves showed symptoms of Asperger's Disorder.

Future studies might unlock the genetic component of Asperger's, says Carl Feinstein, MD, associate director of psychiatry at Kennedy Krieger Institute at Johns Hopkins University. Feinstein says the motor disabilities of the children are another area worth investigating.

Methylphenidate (Ritalin) proved unsuccessful in treating the children; fluoxetine (Prozac) was somewhat effective. One child — the only girl in the sample — had some success on tiny doses of Prozac, but could not tolerate larger doses. She had tried many other medications, but none was effective.

Successful diagnoses and treatment can make all the difference in the lives of these children, Cammuso says. One child, returning to school after treatment, was elected president of his class by his schoolmates. ■

Edward Susman is a freelance writer specializing in medicine. To contact the clinicians, write to them at Bradley Hospital/Brown University School of Medicine, 1011 Veterans Memorial Parkway, East Providence, RI 02915.

Keep your eye on

... the demography of childhood.

The changing demographics of the childhood population, as well as shifting policy concerns, require new strategies for sampling important subgroups of children who are not adequately represented in current federal statistical data. That was one of the conclusions of a workshop convened by the Committee on National Statistics and the Board on Children and Families of the National Research Council and the Institute of Medicine. The workshop report also called for improvements in data collection and sharing. *For a copy of the report, contact the Committee on National Statistics at (202) 334-3096.*

... the family pet.

Dogs that bite children are usually familiar with their victims, according to a new study that finds that children under age 5 face the greatest risk of severe dog bites. Researchers from the Harborview Injury Prevention and Research Center and University of Washington School of Medicine, reviewing 40 dog bite cases in the November issue of *Pediatrics*, and found that 21 dogs belonged to a neighbor, 13 were from the immediate household and only three dogs were strays. Most attacks occurred inside a child's or neighbor's home, followed by the victim's or neighbor's yard.

... abusive discipline.

More than 3 million children are physically abused each year in the name of discipline, based on parents' own reports. The Gallup poll asked a representative sample of 1,000 parents nationwide how they handle a child who misbehaves. If the poll results were projected to the entire population, it would mean that almost 5 percent of parents punish their children by punching, kicking or throwing the child down, or hitting the child with a hard object on some part of the body other than the bottom. Those acts were classified as abusive in the study, while punishments like spanking, slapping, shouting, cursing or threatening to send a child away were not.

... possible risk factor for schizophrenia.

Rhesus (Rh) incompatibility, a cause of hemolytic disease in the fetus and newborn, may be a risk factor for schizophrenia, according to a group of researchers. Hemolytic disease results when maternal antibodies against the fetus's Rh factor D cross the placenta; it can cause permanent neurological damage. J. Megginson Hollister, PhD, and his colleagues, reporting in the January issue of *Archives of General Psychiatry*, found that the rate of schizophrenia was higher in a group of 535 Rh-incompatible men when compared with a group of Rh-compatible men. Since the risk of Rh hemolytic disease increases with second and later Rh-incompatible pregnancies, it's noteworthy that second- and later-born incompatible sons exhibited a significantly higher rate of schizophrenia than second- and later-born compatible sons. The rate of schizophrenia among first-born subjects was not significantly different from that of first-born compatible subjects, as the theory would predict.

... what they don't know.

High school students don't know much about history, a national report card shows. More than half of American high school seniors lack even basic knowledge of U.S. history, and they are unable to use their spotty knowledge to reason, analyze or back up opinions, the National Assessment of Educational Progress (NAEP) found. Although the history test results are discouraging, scores on other NAEP tests over the past decade have shown improvements in math and science. *For a preliminary summary of the data, contact NAEP Publications, PO Box 6710, Princeton, NJ 08541-6710.*

... skinny babies.

Babies who fail to gain enough weight are more likely to commit suicide later in life, according to a group of British researchers. A team from the University of Southamptom checked the child health records of 15,000 people born more than 60 years ago. The 33 men and 10 women in the group who committed suicide all had lowered rates of weight gain in infancy, they found. The subjects' weight at the age of 1 year was about one pound below average. Professor David Barker's team say in the *British Medical Journal* that they found no evidence of parental neglect in the records.

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Commentary

Love isn't supposed to hurt

By Toby Simon, MEd

Nearly a third of the more than 600 high school students surveyed for a recent study interpreted violence as love. What makes this finding even more disturbing is that so many are, in fact, getting this kind of "love." Studies have found that between 12 and 35 percent of teenagers have experienced some form of violence in dating relationships — from pushing and shoving to hitting.

Even though violence in relationships is gaining more media attention, we clearly need to raise awareness at the high school level. Public and private high schools are struggling with how to address this topic in the classroom as well as in the community. Secondary schools and community agencies are just now beginning to realize the importance of helping young people make healthy choices and avoid abusive patterns.

In Essex County, Massachusetts, a program sponsored by the district attorney's office has begun teaching high school students about the dynamics of abusive relationships. Students in the program are learning to recognize the kind of jealousy and possessiveness that can escalate into violence and murder. Some high schools have begun to examine reporting procedures and have drafted specific policies about hazardous student conduct.

They face some intransigent forces. School administrations remain unwilling to "get involved" with cases of dating violence, even though it interferes with classroom participation, academic performance and attendance. And among students themselves, "hazing" and other disruptive behavior is often directed toward students who are not romantically involved.

Why the schools? Teenage victims frequently fail to report incidents to the police or their parents. Therefore, teachers, friends, school nurses, coaches or secretaries may be the first to hear a report of dating violence. In some instances, school systems may have to develop procedures for addressing abusive relations among their students. Schools must uphold their educational responsibility to foster and enhance positive interactions among their students.

The need is twofold: to raise awareness about the nature of abuse, and to educate young women and men about how to make healthy choices in relationships.

The role of peer education in this process may be critical. Peer educators can be powerful voices for discussing highly sensitive topics such as sex, alcohol and other drugs, and acquaintance rape. Already, many high schools have begun training students in upper grades to provide drug and sex education to younger students. Students, who are more familiar with their contemporary culture than are their parents and teachers, can become highly effective facilitators for positive change.

Toby Simon is associate dean of student life at Brown University. She is producing a video on dating violence.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Etiology

Excess lead exposure might contribute to delinquency

Children with high bone lead levels tend to be more aggressive and antisocial, according to a study by University of Pittsburgh researchers. Boys with elevated bone lead levels — but no symptoms of toxicity — were judged by both parents and teachers to be more aggressive, have higher delinquent scores and have more somatic complaints than peers with lower lead levels.

> ***"The appearance of lead-related effects at the median bone lead level suggests that in some samples, lead may contribute to dysfunction."***

The children themselves reported lead-related increases in antisocial acts, according to the study, which appears this month in *The Journal of the American Medical Association.*

High-lead subjects were more likely than low-lead subjects to worsen on all scores of parents' and teachers' Child Behavior Checklist (CBCL) during the four-year observation period.

Herbert L. Needleman, MD, and his colleagues studied 301 public school students whose lead levels were determined by X-ray fluorescence of the tibia. The other outcome measures included the CBCL, teachers' and parents' reports and the boys' self-report of antisocial behavior and delinquency at 7 and 11 years of age.

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Vol. 12, No. 2 February 1996

Inside This Issue

Phobia is more common in adolescents that you might think. Fortunately for most of them, the symptoms are transitory.
See page 4

How divorcing couples can spare their children some of the psychological trauma.
See page 5

A new scale reminds caregivers to take care of themselves too.
See page 6

Coming Up:

How to screen preschoolers for potential developmental problems.

This month's client handout:

Books that help children accept their differences.

Poverty

How homelessness affects children

By Joan Retsinas, PhD

The incidence of adverse events in children such as lead poisoning, asthma, gastrointestinal infections rises as family income falls. Poor children are also less likely to have regular medical providers and, consequently, more likely to use emergency rooms, and more likely to need hospitalization for conditions that earlier treatment might have alleviated.

Once poor children become homeless, their health status plummets further. The conditions that precipitate homelessness — violence, substance abuse, weak family support, dilapidated housing, a drop in income — in and of themselves can plunge children into turmoil. When those conditions propel children on a nomadic trek from one relative to another, ending at a shelter, the children enter a world that is psychologically and physically destructive.

In a shelter, "public mothering" weakens parent-child bonds. In crowded communal rooms, children must witness the full extent of their mothers' anguish, as well as the anguish of other adults. Indeed, shelters that force a child and parent to be together constantly exacerbate the tension.

Rules are often rigid, with set times for meals, chores and "lights out." Play areas are limited, with violations hovering over infractions of rules of breakage of equipment. Sufficient violations, including those caused by a rambunctious child, will

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Homelessness
from page 1

force eviction. A woman who cannot control her children risks appearing unfit — and risks losing them. One parent described life in a shelter as "walking on eggs."

According to a federal estimate, 30 percent of homeless children do not attend school. When they attend, they perform below their poor, but housed, peers on such indices as attentiveness, grade retention and academic achivement. Shelter deadlines (often 30 days) force the parent to focus on finding permanent housing, neglecting the child's schooling. Although legislation allows shelter children to attend their original school, the parent may lack transportation. And a nearby school's documentation requirements, such as health forms, residency forms and birth certificates, may be impossible to meet. If the mother plans to leave the neighborhood when she leaves the shelter, the few weeks of schooling may not be worth the trouble. If the child lacks supplies and clothes, he or she may not want to attend school.

Not surprisingly, researchers, comparing the health status of homeless children to that of poor children with homes, have found that children suffer by virtue of their homelessness. A New York study of babies born to mothers in shelters showed a 16 percent incidence of low birth weight babies, as compared to 11 percent for babies born to public housing residents. The infant mortality figures were 24.9 percent and 16.6 percent, respectively.

The 1987 National Health Care for the Homeless Project, surveying 2,068 homeless people in 17 cities, found that 16 percent of the pediatric sample showed one or more conditions, including cardiac disease, pe-

Slicing up the McKinney pie

Since 1987, the Stewart B. McKinney Homeless Assistance Act has set aside money for the homeless. In fiscal year 1984, Congress authorized $1,197,000,000. The bulk of that money goes to housing. Within the McKinney Act, two programs focus on children of homeless families.

To get homeless children back to school, the federal Department of Education distributed $25.5 million to states in fiscal year 1994, based on a formula (small states receive a $100,000 minimum). With that money, states have made communities relax rigid documentation requirements, established shelter and school-based tutorial programs, distributed supplies, conducted in-service workshops for teachers and hired "homeless liaisons."

For example, Seattle has a special school for homeless children, as well as in-school counseling at six elementary schools. Philadelphia operates six homework centers throughout the city, recruiting a chemical company to donate encyclopedias to each center and a college fraternity to volunteer as mentors. The Contra Costa County Office of Education in California developed a "passport" with school records and health documents to expedite enrollment. New London, CT, conducts a preschool readiness program for children in shelters.

From the overall allocation of $63 million of McKinney money for health care for the homeless, the Department of Human Services carved out $3 million for children. The department currently funds 10 projects, awarded competitively: Montefiore Medical Center Department of Pediatrics, New York, NY: Health Care for the Homeless Coalition, Birmingham, AL; Children's Hospital Medical Center, Oakland, CA; San Mateo, CA, County Department of Human Services; Colorado Coalition for the Homeless, Denver; Health Care for the Homeless Inc., Baltimore; Multonomah Health Department, Portland, OR; Harris County Hospital District, Houston; El Centro Del Barrio, San Antonio, TX. Although children's health care receives a minuscule slice of the McKinney pie, Charles Woodson, administrator of the program at DHHS, doesn't anticipate a new competition.

From 1987 to 1990, the Department of Housing and Urban Development awarded 535 transitional housing grants of $340 million. Grantees leveraged that money by tapping states, other federal programs, local governments, banks and private contributions. Forty-three percent of transitional housing residents are families with children.

In a related program, Supplemental Assistance for Facilities to Assist the Homeless, HUD awards grants that allow maximum flexibility, and many of the grantees incorporate day care, health services and transitional housing into their services.

Apart from the McKinney Act programs, in fiscal year 1994, the government, through the Department of Health and Human Services, funded the following programs that target homeless children living apart from families: runaway and homeless youth, $36.1 million; substance-abusing runaway youth, $14.5 million; and runaway youth in transitional living arrangements, $12.2 million. ■

ripheral vascular disorder, endocrine dysfunction and neurological disorders, compared to 9 percent of a control sample.

In a series of Massachusetts studies, more than half (54 percent) of homeless children in Boston had one serious impairment in language, social skills or motor development, compared to 16 percent of a sample of low-income preschoolers. Using the Simmons Behavior Checklist, the researchers found sleep problems, shyness, aggression, attention deficits and toilet-training problems. According to the Children's Manifest Anxiety Scale and Children's Depression Inventory, half of the school-aged children needed psychiatric referral, compared to 9 percent of the low-income children.

In St. Louis, a study of homeless children found that 89 percent of the children fell at the 50th percentile or lower on the Peabody Picture Vocabulary Test-Revised.

As for the number of homeless children, experts differ. In a 1994 report, a federal Interagency Council on the Homeless compared a series of estimates and concluded that from almost 1 million to 1.32 million children were homeless at some point in the latter half of the 1980s. The government estimates that families comprise 10 to 15 percent of the homeless population, but targeted studies, like that of the U.S. Conference of Mayors show higher proportions. Surveying 27 cities, the conference pegged families at 30 percent of the homeless population.

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Last year, the Department of Education, using state reports, estimated that 745,000 school-age children were homeless (425,465 in elementary school). Clearer data is expected in October from the Census Bureau's year-long National Survey of Homeless Assistance Providers and Clients.

A few programs focus on these children, trying to propel them back to school, to improve their performance; to get them preventive health care, including immunizations; and to counsel them. Ultimately, though, the child's well-being depends on the parent.

The immediate goal is permanent affordable housing — a challenge, given the 1.2 million families on waiting lists for public housing and 1 million waiting for Section 8 vouchers. Homeless families get priority, as do battered spouses, but that does not guarantee a placement or a voucher.

The long-term goal is to alleviate the family's "vulnerability" risk factors. In "transitional housing" programs, mothers can receive prevocational training, vocational counseling and substance abuse counseling, as well as classes in budgeting, nutrition and English. Many programs have on-site day care centers and health clinics. Social workers provide case management. Twenty-two percent of programs offer Parent Anonymous sessions.

Although the family can stay no longer than two years, and most stay less, 90 percent of families who complete the program leave for permanent housing, and staff report anecdotal success stories. Nationwide, the programs serve an average of 12,000 families annually. ■

Joan Retsinas is a freelancer who writes about health and development.

Lead exposure

from page 1

At age 7, borderline associations between lead levels and teachers' scores of aggression, delinquency and externalizing were observed after adjustment for covariates. At age 11, parents reported a significant lead-related association with the CBCL cluster scores of somatic complaints and delinquent, aggressive, internalizing and externalizing behavior.

"The appearance of lead-related effects at the median bone lead level suggests that in some samples, lead may contribute to dysfunction in an appreciable proportion of the community," the researchers say.

They argue for including environmental lead exposure when considering the many factors contributing to delinquent behavior.

But measuring delinquent behavior can be difficult, as is proving the link between the behavior and high lead levels, according to Terrie E. Moffit, PhD, a psychologist from the University of Wisconsin in Madison.

"Because lead was associated with behavior problems reported by boys, parents and teachers, we may be appropriately skeptical of each measure, without being skeptical of the overall finding," Moffit wrote in an accompanying editorial.

Antisocial behavior, like intelligence, is a statistically stable attribute, showing continuities from childhood to adulthood.

"Measures of childhood antisocial behavior are reasonably accurate, broadly applicable and moderately predictive of adult violent crime and related outcomes such as alcoholism and domestic abuse," says Moffit, adding that prediction is improved if delinquency coincides with attention-deficit disorder, another problem that can be lead-related.

"Links between such measures and lead exposure warrant careful attention." ■

What's New in Research

Teens' phobia is common but doesn't last for most

Moderate phobic symptoms are relatively common and, in the majority of adolescents, somewhat transitory in nature, according to a community study. A total of 3,283 adolescents from the Southeast filled out a questionnaire on depressive symptoms. Then 487 pairs of mothers and teens were administered the Schedule for Affective Disorders and Schizophrenia for School-Age Children and the Children's Global Assessment Scale. The prevalence rates of clinical phobia was 2.3 percent; subsyndromal phobia, 14.5 percent; and subthreshold phobia, 22.2 percent. After a year, though, the incidence rates had fallen to 0.4 percent, 8 percent and 16.9 percent, respectively, with 43 percent of phobic subjects categorized at the same or a more severe level after a year. Girls, African-Americans, adolescents not living with both biological parents and older adolescents were more likely to meet the diagnostic criteria for clinical phobia. The majority (77 percent) of subjects with clinical phobia experienced multiple phobias. Subsyndromal (52 percent) and subthreshold (74 percent) phobics were more likely to experience simple phobias only. The findings suggest that characteristic symptomatology and comorbidity may facilitate earlier identification of adolescents at risk of persistent phobia.

"Frequency of phobic disorder in a community sample of young adolescents," Jennifer M. Milne, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(9):1202-1211, 1995. For reprints, write to Dr. Carol Z. Garrison, Department of Epidemiology and Biostatistics, School of Public Health, University of South Carolina, Columbia, SC 29208.

Behavior-disorder kids at greater risk of accidents

Children with behavior problems are at higher risk for unintentional injuries than those without behavior problems, according to a cross-sectional analysis of data on 11,630 children contained in the 1988 National Health Interview Survey. Researchers examined the annual incidence of unintentional injury and its relationship to child behavioral problems among three ethnic groups (white, African-American and Hispanic). Accident rates were higher among white children (17.9 percent) than in African-American or Hispanic children (both 9.3 percent). The odds of unintentional injury in children with severe behavioral problems was 1.65 times greater than in children without behavioral problems, after controlling for relevant sociodemographic characteristics. While ethnicity did not alter the relationship between overall behavioral problems and increased injury rates, ethnic differences emerged in the subscale analyses of disruptive behaviors. These findings call for targeting accident prevention strategies to children with behavioral disorders.

"Relationship between behavioral problems and unintentional injuries in U.S. children," Regina Bussing, et al., *Archives of Pediatrics and Adolescent Medicine*, 150:50-56, 1996. For reprints, write to Dr. Bussing, University of Florida Health Science Center, Box 100177, Gainesville, FL 32610-0177.

Ritalin curbs hyperactivity in children with autism

Methylphenidate (Ritalin), the psychostimulant widely prescribed for attention-deficit hyperactivity disorder (ADHD), may be useful in the treatment of hyperactive children with autism, according to a double-blind, crossover study. Ten autistic children, ages 7 to 11, took two doses of Ritalin (10 mg or 20 mg twice a day) and placebo. The children showed modest but statistically significant improvement on Ritalin over placebo. They also became less hyperactive. Neither dose was associated with significant side effects, including worsening of stereotypic movements.

"Use of methylphenidate in the treatment of children with autistic disorder," Humberto Quintana, Boris Birmaher, et al., *Journal of Autism and Developmental Disorders*, 25(3):283-294, 1995. For reprints, write to Dr. Quintana, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, PA 15213-2595.

Many anxious patients have history of childhood abuse

A history of childhood abuse may be more common among people with anxiety disorders than in the general population, according to a new study. The study also found a particular association between sexual abuse and panic disorder in women. A standardized interview with an extensive series of trauma probes was given to 125 women and men with DSM-IV anxiety disorders (panic disorder, social phobia or obsessive-compulsive disorder) and to the same number of age- and gender-matched subjects from the community. Almost one-fourth of patients with anxiety disorders — 33.3 percent of women and 15.5 percent of men — reported experiencing childhood physical abuse, compared to 8.1 percent in the comparison group. Because a history of childhood sexual abuse was rare in men, the researchers limited this comparison to the women. Twenty-three (45.1 percent) of 51 women with anxiety disorders reported experiencing some form of sexual abuse before age 18, compared to eight (15.4 percent) in the comparison group. The reported rate of sexual abuse was significantly higher in women with panic disorder than in women with other anxiety disorders.

"Childhood physical and sexual abuse in patients with anxiety disorders and in a community sample," Murray B. Stein, et al., *American Journal of Psychiatry*, 153(2):275-277, 1996. For reprints, write to Dr. Stein, Department of Psychiatry (0603), Anxiety and Traumatic Stress Disorders Research Program, University of California at San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0603.

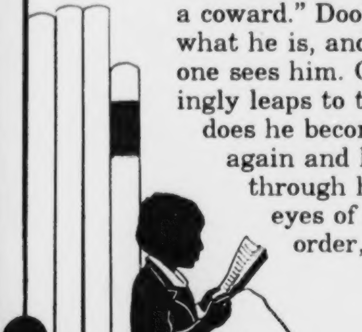
Books that help children accept their individual differences

When so many peers encourage conformity, children may have trouble accepting their individual differences. The following books can help your child to take pride in his or her unique background, attributes, and abilities. Most of the books can be found in your public library or local bookstore. Where available, ordering information from the publisher is provided.

- *All I Am*, by Eileen Roe, [Bradbury, 1990]. Using simple language, one preschooler tells readers that he is a friend, neighbor, animal lover, artist, *etc.* This book encourages feelings of positive self-worth and provides a boost to self-esteem. Ages preschool and up. To order, call: (800) 257-5755.

- *Clive Eats Alligators*, by Lester Alison [Houghton Mifflin, 1986].For breakfast, Frank has granola; Celeste has tea and toast; Nicky has a banana; Ernie has porridge; and Clive eats alligators. Seven children, each different from the others in many ways, show how we're all different, individual, and special. Ages 4 to 8. To order, call: (800) 382-0602.

- *Chicken* by Tricia Tusa [Macmillan, 1986]. When Dooley, a young, adventurous chicken, wonders why he can't fly like other animals with wings, he's told it's because he's a chicken. He looks "chicken" up in the dictionary, and reads that it means "timid, afraid, a coward." Dooley believes that this is what he is, and that this is how everyone sees him. Only when he unthinkingly leaps to the defense of his friend, does he become his old true self again and learns to see himself through his own eyes and not the eyes of others. Ages 5 to 8. To order, call: (800) 257-5755.



- *Free to Be . . . You and Me*, by Marlo Thomas [McGraw, 1987]. It's a song book, story book, picture book, and poetry book to help children feel free to be who they want to be — not what they should be or ought to be, but what they can be. It's a fun book that opens new possibilities for growth and change. Goodbye to sexism, racism, and myths such as pretty equals good, all moms are in the kitchen, and big boys don't cry. All ages. To order, call: (800) 382-0602.

- *I Like Me*, by Nancy Carlson [Puffin, 1993]. This little pig really feels good about herself. She is her own best friend. She takes good care of herself, knows how to cheer herself up, and when she makes a mistake, she just keeps trying until she gets it right. Ages 4 to 7. To order, call: (212) 366-2000.

- *I Wish I Were a Butterfly*, by James Howe [Gulliver Books/Harcourt Brace, 1987]. When a grumpy frog tells the smallest cricket that he is the ugliest creature in the pond, maybe even in the whole world, little cricket believes him. The little cricket gets very sad and longs to be beautiful like a butterfly. With the help of his friend, a wise spider, the cricket comes to realize how special and unique he is. And a beautiful butterfly, passing by and hearing the sound of the cricket's music, wishes that he were a cricket. Ages 4 to 8. To order, call: (800) 346-8648.

- *People*, by Peter Spier [Doubleday, 1988]. A great big colorful book celebrates the 4 billion people on earth — all people, in their many homes, colors,

Continued on next page . . .

. . . *Continued from previous page*

and religions. We're each different, each a distinctive individual, and each of us experiences life and expresses feelings in a unique way. All ages. To order, call: (800) 382-0602.

- *Nobody's Perfect, Not Even My Mother*, by Norma Simon [Whitman Concept Book, 1981]. Some of us are good at some things; others are good at other things. Even though everyone is good at some things, nobody is perfect at everything. But that doesn't mean that we don't try! Ages 4 to 8. To order, call: (800) 382-0602.

- *No Good in Art*, by Miriam Cohen [Greenwillow, 1986]. Jim's artistic efforts get squashed by an insensitive kindergarten teacher convincing Jim that he cannot draw. Encouragement and praise from Jim's first-grade art teacher and classmates restore his confidence in his artistic talents. Ages 5 to 8. To order, call (800) 843-9389.

- *Otto Is Different*, by Franz Brandenberg [Greenwillow, 1985]. Otto Octopus doesn't want to be different. He wants to be just like his friends. His father points out that with eight arms, he can do his work four times faster than his friends. Otto can brush his teeth, wash his face, blow his nose, and tie his shoes all at the same time; that's only using five of his arms. Otto realizes another advantage of being himself: Who else gets hugged with eight arms? Ages 5 to 8. To order, call (800) 843-9389.

Reviews by Barbara Goldberg, MLS. Ms. Goldberg is a contributing editor to *All Kids Considered*, an independent parenting publication.

The Brown University Child and Adolescent Behavior Letter

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Prepared by Mary-Kim Arnold, editorial assistant.

Divorce

Teach ex-spouses how to cope to protect children from trauma

Last year, more than 1.2 million children experienced the breakup of their families, and the American Bar Association's Family Law Section is promoting parent education as a way to protect these children from at least some of the psychological trauma and emotional scarring often associated with divorce.

The ABA's Family Law Section recently joined with the association of Family and Conciliation Courts to set up a task force to promote and implement divorce and separation education programs for parents, thereby minimizing the negative effects on children.

Current programs vary by state, ranging from mandated education for all divorcing parents in Connecticut and Utah to eight states currently without any formal programs available.

"How the parents behave during the divorce proceedings is the single most important element in how the children survive the experience," explains Timothy Walker, chairman of the ABA's Family Law Section and a professor at the University of Denver College of Law.

Divorce education is generally conducted by social workers, counselors or psychologists. Some charge a small fee, but no one is turned away based on their economic status. The majority — 67.8 percent — of participants, attend one two-hour education session.

Some of the issues covered in these sessions include:

- The divorce and separation process and its stages.
- The nature and effect of custody litigation on parents and children.
- Parents' legal and moral obligation regarding child support.
- How the court decides child suport issues.
- The impact of divorce and separation on children and how to reduce it.
- How the legal process works and what options are available to both parents.

"When children are involved, divorce and separation should be viewed, not as the end of the family, but simply as a reorganization of the family unit," adds Andrew Schepard, a member of the joint task force and a professor of law at New York's Hofstra University.

Schepard is one of the founders of Parent Education and Custody Effectiveness (PEACE), a New York state educational program in effect since 1992. Start Making It Livable for Everyone (SMILE) In Michigan, KIDS FIRST in Maine and KIDS TURN in San Francisco are examples of programs with similar goals.

Ongoing studies will measure the effectiveness of these new programs, but the anecdotal evidence so far has been promising. "Parents come away feeling that they aren't alone," says Mark Robbins of Arizona, one of the Family Law Section members involved in setting up programs nationwide. "Their parenting responsibilities have been reinforced, and their commitment to their children's well-being is strengthened." ■

Kicker

National screening for eating disorders kick off

The first-ever National Eating Disorders Screening Program this month, with 629 participating colleges, is expected to reach an estimated 2.5 million students.

The screening program, which has been organized by coordinators of the National Depression Screening Day and National Anxiety Disorders Screening Day projects, coincides with Eating Disorders Awareness Week, Feb. 5-9. The program's purpose is to reach young people who have symptoms of eating disorders before they need emergency treatment or develop a full-blown disorder.

The screening day will provide an educational presentation that includes a video with interviews of women who have had eating disorders; a written screening test; and an opportunity to meet with a health care professional for information and referrals.

Unlike the other national screening programs, the inaugural eating disorders screening is focusing only on colleges and will be administered through health and counseling centers on campus, says Stacy Silveira, a project associate.

A study published in the November 1995 issue of the *American Journal of Psychiatry* found that 10 percent of young women on college campuses have a clinical or near clinical eating disorder. About half of these women suffer from bulimia nervosa.

The program will expand into the community next year. Ultimately, those involved with the project hope the screening can be introduced at the high school and junior high levels. ■

Keep Your Eye On

... weight of WIC-fed children.

Despite recent concern that foods provided by the federal government were making poor preschoolers fat, differences in weight status among children who participated in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and those who did not participate were neither significant nor consistent among white and black children, according to the Centers for Disease Control and Prevention (CDC). However, the percentage of energy obtained from fat was higher for WIC participants than non-participants. (*Morbidity and Mortality Weekly Report*, Jan. 26)

... young gunmen.

Arrests of juveniles comprise an increasing proportion of weapons offense arrests. Juveniles accounted for 23 percent of those arrested for weapons offenses in 1993, compared to 16 percent in 1974. Between 1985 and 1993, the number of juvenile arrests for weapons offenses increased by more than 100 percent, from just under 30,000 to more than 61,000. At the same time, adult arrests grew by 33 percent. Among all age and gender groups, 18-year-old men have the highest per capita arrest rates for weapons offenses. (U.S. Bureau of Justice)

... and young killers.

A pair of Chicago children, charged with the murder of a 5-year-old, are at the center of a national debate about how to handle the youngest killers: Should they be locked up like little adults, or should they be sent to secure residential treatment centers where they can get intensive counseling? Before Eric Morse was killed, children under age 13 in Illinois could not be sent to a juvenile prison. Afterward, the law was quickly changed to make children as young as 10 eligible to be locked up. (*New York Times*)

... bilingual education.

A new study is likely to reignite controversy about the best way to teach students who don't speak English at home. Researchers at George Mason University in Fairfax, VA, found that students taught first in their native language do better in the long run than those immersed quickly in English. Looking at school records, socioeconomic status and parents' education level for 42,000 students, they found that, regardless of the teaching approach, student scores on a variety of standardized tests remained stable through at least fourth grade. But by seventh grade, the English immersion students' scores had begun to drop, plummeting to below the 20th national percentile by the end of middle school. (*School Board News*, Jan. 23)

... the self-perceptions of children with ADHD.

Although children with attention-deficit hyperactivity disorder (ADHD) have trouble in school and with their peers, research has shown that these children do not display a negative sense of self. In fact, they tend to rate themselves as high, or higher, than comparison children when asked to predict how well they would do on a task or in a social situation. One explanation is that the optimism is serves a self-protective role. "Their distorted perceptions may serve as a buffer to shield them from some of the negative effects surrounding their frequent failure," say Richard Milich, PhD, and Mary Beth Diener, MD, from the University of Kentucky. (*The ADHD Report*, October 1995)

Assessment

Caregivers get help fighting burnout

A new scale encourages people who care for children or elderly family members to also take better care of themselves. The scale can help caregivers identify areas of their lives where they are doing well, and areas where they might need help, according to its developer, Susan Tebb of St. Louis University's School of Social Service.

The 45-question, self-administered scale assesses caregivers' strengths, not only their limitations. It can provide clinicians with information on how to better assist clients caring for family members, Tebb says.

"With the information obtained from the scale, social workers and caregivers can make plans that might again provide the caregivers with some enjoyment in daily life," Tebb said in an article in *Health and Social Work*.

The scale attempts to measure how well caregivers meet their own basic needs and fulfill activities of daily living. Basic human needs include: expression of feelings (love, sexuality); physical needs (sleep, recreation, diet, medical and dental care); security (having a home and enough money, making plans for the future); and self-esteem and esteem from others.

Daily living activities cover time for self (fun, relaxation, reflection, inspirational interests); household maintenance (shopping, cooking, cleaning); leisure activities (hobbies, exercise, social events); functions outside the home (employment, etc.); and support from family and friends.

It is estimated that family caregivers save millions of dollars by helping individuals avoid the need for institutional care. ■

At the Library

Kids get help adjusting to a new baby

The arrival of a new brother or sister can give rise to conflicting feelings in young children. They may be happy at the prospect of a new friend, but disappointed by — and sometimes jealous of — the helpless and demanding newborn.

With sensitivity and humor, the following books for new or about-to-be big brothers and sisters examine the challenges and joys of adjusting to a new sibling. These picture books, which are available at most libraries, are suitable for preschoolers to 8-year-olds.

This Baby — *Julia McClelland, Houghton Mifflin, 1994*

From the time kindergartner Andrew, a bear, can't sit on his mother's lap anymore, he feels the new baby has already taken his place. He stomps, he sulks, he gets angry, he sniffles, he shouts, he throws things. He makes up ugly names for his sibling-to-be. He can't figure out why his parents want another baby when they already have him. His parents explain how the baby will need a good friend like Andrew to teach him or her things.

Aren't You Lucky! — *Catherine Anholt, Little, Brown & Co., 1991*

"Aren't we lucky!" a little girl is told by her father. "Mom is going to have another baby." First, there was the nine-month wait, followed by the hospital visit, then the homecoming of what looked like a "raspberry" who couldn't talk, walk or play. "Aren't you lucky!" said all the relatives and friends when they came to see the new baby. This older sister didn't think she was lucky at all. One day, mom got tired and wished aloud for a big girl to help her with the baby. Now, big sister and little brother do lots of things together. When people see them together, they say, "Isn't he lucky!"

Darcy and Gran Don't Like Babies — *Jane Cutler, Scholastic, 1993*

Gran was the only one who understood. Darcy just didn't like the new baby. As a matter of fact, she never did like babies. They smell bad, look funny, make too much work and get too much attention. Gran and Darcy go to the park for a "big-girl-only" time together on the big swings, teeter-totter, jungle gym and tall slides where babies can't go. Gran thinks it might be OK not to like the baby now. Maybe they both really do deep down, and maybe, just maybe, they'll both like the baby more later.

Julius The Baby of The World — *Kevin Henkes, Greenwillow, 1989*

A truly funny look at how big mouse sister Lily goes from being the best big sister in the world before Baby Julius is born to deciding she is queen and she hates Julius after he is born. Although her parents think that Julius is "the baby of the world," Lily thinks he's disgusting and should be given away. That is, until cousin Garland comes to visit and voices her opinion.

Geraldine's Baby Brother — *Holly Keller, Greenwillow, 1994*

Even though Geraldine wanted a baby brother, she didn't mean *that* one, the one she got. Earmuffs aren't enough to stop her from hearing "it" cry, and she resents all the attention he gets from everybody. One night, Geraldine hears Willie moving around in his basket, and she goes into the nursery to demand "no more crying," but stays to spend some time and become friends.

Compiled by Barbara Goldberg, MLS.

Coming Up

Infancy Institute to meet

The ninth annual Bank Street College Infancy Institute, "Infants, Toddlers, Parents: Supporting Their Growth," will be held June 26-28 at Bank Street College in New York City. The institute is designed for caregivers, family child care providers, directors and coordinators who serve children from birth to age 3 and their families in child care, parent support programs, teen parent programs and early intervention. **Call:** Dr. Nancy Balaban or Dr. Virginia Casper at (212) 875-4713 or **fax** (212) 875-4753.

Child abuse conference

The 11th National Conference on Child Abuse and Neglect will be held Sept. 16-21 at the Washington, DC, Hilton and Towers Hotel. Sessions will address prevention, intervention and treatment in the areas of program, research, policy and practice. **Call:** Research Assessment Management at (301) 589-8242 or **fax** (301) 589-8246.

Policy fellows sought

Columbia University's Center for Young Children and Families is accepting applications for its summer fellowship program in child and family policy. "Putting Children First" offers full-time placement from June 4 to July 30 in a variety of policy settings in New York City government and non-profit agencies. **Application deadline:** April 1. **Write:** Dr. Judith Smith, Center for Young Children and Families, Teachers College, Columbia University, Box 39, 525 W. 120th St., New York, NY 10027 or **call** (212) 678-3904.

Managed care for kids

The Lehr Institute will present a two-day seminar on "Managed Care for Children" Feb. 29 to March 1 in Orlando, FL. **Call:** Dottie Frankenfield at (800) 634-8237.

Commentary

A child's-eye view of the media

By James W. Prescott, PhD

The recently released report from the U.S. Advisory Board on Child Abuse and Neglect, "A Nation's Shame: Fatal Child Abuse and Neglect in the United States," has documented some 2,000 annual violent deaths of children 4 years old and younger due to child abuse and neglect. Another 18,000 have been permanently disabled, and 142,000 seriously injured due to violence.

The brutality of much of this physical violence against infants and children, which occurs primarily in the home, eerily matches what is often seen on television and movie screens. When the entertainment media dramatize parents killing children, children killing parents, and now children killing children, can it be claimed that such media events are only a mirror reflection of the real world? Or do these violent media events actually help forge the reality? There is ample evidence that both forces are at work in a cruel synergy.

We need to recognize that the dynamic visual image has a unique psychological effect that is not shared by the written or spoken word or still graphic image. It is not meaningful to equate the psychological effects of the dynamic visual image with that of the written word, auditory image (as in storytelling) or static graphic image. Many criticisms and constitutional questions being applied to the moving picture should not apply to the printed or spoken word or to the still image.

This point is self-evident for those of us who remember the great radio shows before the advent of television, like "The Shadow," "The Green Hornet" and "The Lone Ranger." The child constructs his or her own visual imagery to correspond with the auditory images of these storytellers. The child does not construct visual images that he or she cannot handle psychologically. *Moving* visual media images strip away this creative and protective mechanism.

We need to re-evaluate, with sound and well-defended studies, the dynamic visual-auditory media (TV, films and songs, as well) that compel behavior, particularly when it involves the glorification and advocacy of violence. Hollywood should have no license to advocate or commit rape, mutilation and murder in the name of free speech.

The intent of the First Amendment needs to be re-evaluated within the context of this scientific perspective, where the dynamic visual media can have such a profound and controlling effect on any of us, but particularly on the mind of the child.

Our founding fathers, in providing protection for political and religious free speech and press in the transmittal of information and ideas among adults, certainly did not envision technologies that could compel the opposite — a loss of freedom to choose and to protect oneself, and one's children, from the messengers of violence and destruction. ■

Excerpted from "Hollywood Violence ... First Do No Harm," James W. Prescott, *Imagine a World of Wanted Children*, August 1995. For a copy of the full article, write to: *Imagine a World of Wanted Children*, P.O. Box 1001, San Jacinto, CA 92581. The author is a developmental neuropsychologist and a cross-cultural psychologist who has specialized in the study of the developmental origins of violence and peaceful behaviors. He is currently director of the Institute of Humanistic Science in Newport Beach, CA.

The Brown University **Child and Adolescent Behavior Letter**

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Assessment

How to screen preschoolers for developmental problems

By Doris Aaronson, PhD

Much time and money are spent on the developmental screening of preschoolers, including evaluation of cognitive, motor, language, social and perceptual abilities. Since important educational decisions are based on such screening and since screening of large numbers of children must be done quickly and cost-effectively, subsequent comprehensive assessment may be necessary for those few who may be at risk for developmental delay.

The Individuals with Disabilities Education Act (IDEA) requires that children who may need special services be identified. For this purpose, Head Start requires that systematic screening be used. It is generally too costly to do three- to six-hour diagnostic testing of all children, especially by highly trained pediatricians and psychologists. But brief screening often does not require intensive training and can be done by the children's teachers. Children who obtain low screening scores can then be referred for in-depth assessment.

Sharing test results with parents can optimize their child's development.

Many additional benefits may come from screening,

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Vol. 12, No. 3 March 1996

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Three to 5 percent of all American schoolchildren are on Ritalin — a figure that worries the International Narcotics Control Board.
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Growing up with violence can ignite a vicious cycle.
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Aggressive boys who are rejected by their peers have worse social outcomes than boys who are either aggressive or rejected.
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Coming Up:
The world of the infant

This month's client handout:
Does your child have a gambling problem?

Peers

Good looks count during childhood

By Jason Kachel

On a yearly basis, the American obsession with physical appearance supports a $300 million plastic surgery industry, a $20 billion cosmetics industry and a $33 billion diet industry. In addition, the media constantly bombard us with images of ideal bodies. This emphasis on beauty appears to be trickling down to even the youngest among us.

Physical attractiveness stereotypes among young children not only exist, they play a major role in determining popularity, which, in turn, determines how much the child enjoys school. Moreover, teachers show biases toward attractive children, who are believed to have more academic potential than unattractive children.

The power of physical attractiveness on popularity can be seen as early as preschool. In a study of children's stereotyping of facial attractiveness, 3- to 6-year-olds looked at same-sex pictures of both attractive and unattractive faces of children of the same age whom they did not know. They were asked to choose two children whom they would like as friends and two whom they would not. Then they chose which children would fight a lot and be harmful, and which others would avoid fighting and be helpful. The children consistently showed preferences for attractive kids to be their friends and a corresponding dislike for unattractive kids. They also said that the attractive children were more likely to be pro-social and the

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Screening

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such as getting to know the individual strengths and weaknesses of each child; providing an annual record of each child's development; improving the preschool educational curriculum, based on scores for an entire class or county; and interpreting results in the context of the child's environment. Sharing results with parents or guardians and involving them in action plans can optimize the child's emotional, social, physical and intellectual development.

Here are three factors important in selecting screening devices:

❶ Sources of information about the child

Screening information usually comes from parents' reports based on surveys, questionnaires or interviews; behavioral observations by trained personnel such as a teacher or social worker; and the child's own responses to test items. All three types of information should be used, and a quantitative profile of each child's abilities should be compiled.

❷ Reliability

The screener's reliability can be affected by measurement error, or variability caused by mood, fatigue or other transient factors. The sample size used in developing the screening tool should be large so that transient factors, idosyncratic to each participant, will be reduced relative to the primary attributes being measured.

Test-retest consistency is an important index of reliability. Repeat testing by the same screener or alternate screening forms should yield similar scores. If the child scores high one day and low a few days or weeks later, the instrument is suspect. This will show up in group data as low statistical correlations between the two screenings. With correlations ranging from 0 to 1, a correlation of 0.5 is not bad, but at least 0.75 is desirable.

Inter-item consistency is another indicator of reliability. A screener should have different items or questions measuring the same attribute, like motor skill, and the items should confirm one another's findings. Statistical correlations index inter-item agreement, with about 0.75 again being desirable.

❸ Validity

The most important property of a screening tool, validity must measure what is intended, or predict something useful, such as the child's future performance.

Reliability and validity are not arbitrary features when selecting a screening tool.

The next question is how to interpret and act on a given child's screening score. Screening scores are usually higher for normal than for developmentally delayed children — but not always. As no screening instrument is completely reliable or valid, and as environmental variability may cause children or testers to have good or bad days, scores for normal and delayed children will have considerable overlap.

How do we decide on a cutoff for identifying children who should go on for further in-depth assessment, to reduce the possibility of errors of identification? Some states arbitrarily require that children who score in the lowest 7 percent on the screening test be administered in-depth testing; others, the lowest 16 percent. Other states use age delay as an indication for follow-up testing. For example, a 50 percent age delay means that a 4-year-old child performing at the 2-year-old level would be retested and all others "passed."

If the cutoff selecting for more intensive examination is set liberally — to tag a large number for full-scale testing — it will include too many false positives. If the cutoff is set too far in the opposite direction, too many false negatives will occur. Labeling a child as deficient has adverse effects on children and their parents; at the same time, not detecting those in need can have disastrous life-span consequences.

In reality, the cutoff may not be determined by age and ability norms provided by the test developer, but rather by available resources, usually money, for testing and remedial services. Thus, cutoffs vary from state to state, and may be influenced by the politics of funding. ■

Doris Aaronson is a professor of psychology at New York University. She and May Aaronson, an early childhood consultant, developed the Children at Risk Screener (CARS), which tests children's knowledge of spatial prepositions, such as "over," "under" and "above." For more information on CARS, write to her at the NYU Psychology Department, 8th Floor, 6 Washington Place, New York, NY 10003.

Meeting highlights infancy

The 10th biennial International Conference on Infant Studies will be held April 18-21 at the Westin Hotel in Providence, RI. Among the speakers will be Jerome Kagan, on early origins of personality; Elizabeth Bates, on brain and language in infants and adults; and Edward Zigler, on solving the child care crisis. For a registration form, write to the editor of The Brown University Child and Adolescent Behavior Letter, Lewis P. Lipsitt, PhD, 1996 ICIS Conference Chair, Box 1853, Brown University, Providence, RI 02912.

Psychopharmacology

Agency survey reports overuse of Ritalin among U.S. children

A survey released last week by the Vienna, Austria-based International Narcotics Control Board documents a dramatic increase in the use of the stimulant methylphenidate (Ritalin), prescribed most commonly for attention-deficit disorders, among children in the United States.

Ritalin is being prescribed for 3 to 5 percent of all American schoolchildren, and most of those taking the drug are boys, the worldwide drug-use survey reports. The narcotics control board estimates that 10 to 12 percent of all boys between the ages of 6 and 14 are on the drug.

Worldwide, use of the drug has increased from less than 3 tons in 1990 to more than 8.5 tons in 1994, with the United States producing and consuming about 90 percent of that amount.

Use of Ritalin poses potential dangers to the overall health of children and also carries the risk of adolescent addiction, board members say. Children in the United States are prescribed the drug for longer periods of time than are children in other countries, the report finds.

The report states that an influential parents' group that supports the drug's use is receiving significant financial contributions from a drug manufacturer. While the report does not mention either the group or the drug firm, *The New York Times* reported that the group is Children and Adults with Attention Deficit Disorder and the pharmaceutical company is Switzerland-based Ciba-Geigy, manufacturer of Ritalin.

Ciba Pharmaceuticals of Summit, NJ, responded that the drug has been proved safe for more than 40 years and that its use has increased of late because diagnoses of attention-deficit disorder have become more accurate.

Recent news reports have told of a rise in illicit Ritalin use among teenagers who seek the energizing effects of the stimulant, believe the drug is safe and find it readily available at low cost. ■

FDA clears use of Adderall for attention-deficit disorder

The Food and Drug Administration (FDA) has approved a new drug application for the use of Adderall for patients with attention-deficit hyperactivity disorder (ADHD). Adderall is indicated for use in children 3 years of age and older with ADHD as a part of a total treatment program, which typically includes psychological, educational and social measures.

Adderall may improve attention span, decrease distractibility and increase the ability to follow directions and finish tasks, according to its manufacturer, Richwood Pharmaceutical Co. in Florence, KY. The therapy may also improve the patient's ability to think before acting, decrease hyperactivity and even improve legibility of handwriting, Richwood says. In addition, aggression may decrease in youngsters with ADHD.

"Those with ADHD need to have as many therapeutic options available as possible. We have found that many patients will go through two or three drugs before finding the medication that is most effective and best tolerated," says Robert Hunt, MD, a psychiatrist and researcher with the Center for Attention and Hyperactivity Disorders in Nashville. "Our experience with Adderall has been very positive. We are in the midst of conducting clinical trials that should give us some additional insight into use of this treatment."

Adderall, which comes in 10 mg and 20 mg double-scored tablets, is generally well-tolerated with few adverse reactions reported. The most frequently reported adverse reactions include anorexia, insomnia, stomach pain, headache, irritability and weight loss. As with most psychostimulants indicated for ADHD, the possibility of growth suppression and the potential for precipitating motor tics and Tourette syndrome exists with Adderall treatment, and in rare cases exacerbations of psychosis have been reported. And like other psychostimulants, Adderall poses a high potential for abuse. Its advantage, according to the manufacturer, is that it's one of the least expensive therapies for ADHD.

Adderall had previously been approved and marketed by another company under the name of Obetrol, indicated for exogenous obesity and ADHD. Richwood acquired the company, including the formulation and manufacturing rights to Obetrol, and renamed the drug Adderall in 1994.

Soon after the acquisition, the FDA decided to review the reformulated product application, which was originally submitted in the 1970s. For the past year, while Richwood completed the paperwork requested by the FDA, Adderall was only available under investigational new drug status to patients who were already taking it before November 1994. ■

Good looks

from page 1

unattractive kids to be antisocial. No gender effects were noted.

In a different study, preschoolers were presented with head shots of their classmates. To measure peer acceptance, each child was asked to rank the likeability of their same-sex classmates. For girls, the children who ranked highest tended to be the most attractive. But the relationship did not hold up for boys. Studies demonstrate an interaction among gender, popularity, knowing a person and attractiveness.

For elementary school children, physical attractiveness is more important to peers than athletic ability and sociability in determining popularity. Third-graders were shown pictures of two attractive and two unattractive kids (measured by adult standards) whom they had never seen before. A combination of characteristics was manipulated: physical attractiveness, sociability and athletic ability. Subjects were asked which child of the same sex they would like as a friend. Boys and girls overwhelmingly chose the attractive over the athletic and sociable child.

Because physical appearance is hard to change, children enter school with their popularity almost predetermined — a haunting prospect, considering the evidence for the effects of popularity on social adjustment. For example, about 2,500 high school students who had been followed from elementary school yielded data that showed those students with a low peer status in elementary school were two to three times more likely to avail themselves of mental health treatment in high school. When these same young people were followed up at age 26, 15 years after elementary school, childhood peer rejection was still significantly related to mental health problems.

In another study, boys rejected by other boys in elementary school had a higher rate of delinquency five years later. There was no delinquency among boys who were "accepted."

The power of physical attractiveness extends into the academic arena. Teachers seem to have a covert bias toward physically appealing children; they see more potential in attractive kids.

Researchers distributed 400 fictional academic records to fifth-grade teachers. Each record contained the same above-average report card and a photo, either of an attractive or unattractive student. An opinion sheet was attached to the record on which teachers were asked to estimate the IQ of the child and rate how sociable the student would be, parental attitude toward education, and how far the child would go educationally. An attractiveness stereotype was found in the teachers, both men and women. Teachers expected attractive kids to have higher IQs and better peer relations and to remain in school. Teachers also felt that parents of attractive students would be more interested in their child's academic achievement than would the parents of unattractive children.

This attractiveness stereotype for parental attitude was seen when teachers explained the gradual increase in the fictional students' grades. For pictures of unattractive students, teachers tended to focus on poor parts of the academic record, gave a low score on parental attitude and remarked that the child's attitude suggests parental neglect of negative behavior at home. When an attractive child was pictured, the teacher emphasized the positive aspects and gave a high score for parental attitude.

In another study, the faces of attractive and unattractive children were attached to a record from a below-average fictional student that showed an IQ of 78 and evidence of immaturity, but no behavioral problems. Teachers were asked whether the children should be placed in a special class for mentally retarded students, whether the child would experience difficulties with peers, and whether future academic difficulties should be expected. The results? Teachers thought that a special class was more appropriate for unattractive children, and further psychological evaluation would reveal lower functioning and more difficulties in peer relationships.

The effect of attractiveness appears to be strongest when explicit information about the child's competence is absent. If a less attractive student takes an active role in displaying skills to the teacher, the bias may occur less intensely, or even not at all. But if the less attractive student is shy, for example, then the teacher's view may be based on first impressions.

Studies on physical attractiveness usually rely on photographs of faces as independent variables. While the face is the feature from which physical attractiveness is primarily judged, personality, personal knowledge and other characteristics of the child will also affect perceived physical attractiveness. Experiments have only begun to reveal the complexity that physical attractiveness contributes, among many variables, to peer popularity and teacher expectations.

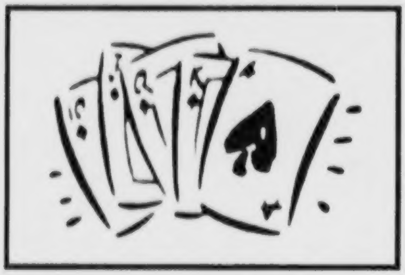
Future studies should reach beyond middle- and upper-middle-class white children. It is likely that race, socioeconomic background and culture affect perceived physical attractiveness. ■

Jason Kachel is a writer and student at Brown University. For more information, write to him at Box 3113, Brown University, Providence, RI 02912.

Does your child have a gambling problem?

Does your child spend a lot of free time playing poker or dice games, or betting on sports? Does your child argue with you about gambling, or use money that was intended for another purpose — clothes, CDs, food — for gambling instead? If so, your child may have a gambling problem.

According to Durand F. Jacobs, Ph.D., a clinical psychologist who works with teens and children who gamble excessively, one of every two legally underaged adolescents gambles. Yet there seems to be little public recognition or concern with teenage gambling.



Jacobs says that across the country, teens start gambling long before entering high school. More than a third report their first experience with gambling for money before the age of 11 years, and 70 to 88 percent started gambling before they were 15.

The games that teenagers play most commonly for money are:

- cards with family and friends;
- the lottery;
- games of skill, such as bowling, golf, and pool; and
- betting on sports.

If you think that your teen spends an excessive amount of time playing games that usually involve money, pass along the short self-test at the end of this flyer.

Danger of compulsive behaviors

Compulsive gambling — characterized by periods of intense excitement, followed by desperate attempts to win back losses — is a serious problem. According to Henry Lesieur, Ph.D., some researchers have found common personality traits among compulsive gamblers and chemically dependent individuals. While your teen's gambling may not seem to be problematic, the behavior may indicate an underlying problem, and should be taken seriously.

If you think your teen has a problem with gambling, talk to a school counselor. In addition, many local alcohol or drug abuse treatment centers also address gambling. Check your yellow pages for contact information.

For further information on treatment resources available for problem gambling, contact the National Council on Problem Gambling, 445 West 59th Street, New York, NY 10019; (212) 765-3833 or (800) 522-4700.

Self-Test for Teens

Respond to the following questions by circling yes or no:

Do your friends gamble a lot?	YES/NO
Do you gamble at school?	YES/NO
Have you ever skipped school or work to gamble?	YES/NO
Is gambling more important than school or work?	YES/NO
Do you often spend your free time involved in gambling activities, like playing poker, betting on sports, playing dice, etc.?	YES/NO
Do you think gambling is the most exciting thing you do?	YES/NO
When you are gambling, do you lose track of time, and forget other things?	YES/NO
Do you often daydream about gambling?	YES/NO
Do you feel that your friends are jealous of you when you win money at gambling, and that you get extra attention because of gambling?	YES/NO
When you win, do you usually want to keep playing because you feel that you will continue to win?	YES/NO
When you lose, do you feel that you must bet again as quickly as possible to win back what you've lost?	YES/NO
Do you gamble with money that was meant for other things — like lunch, clothing, CDs, etc.?	YES/NO
Do you ever borrow money to gamble?	YES/NO
Have you ever sold a possession to get money for gambling, or to pay a gambling debt?	YES/NO
Do you try to keep your gambling secret from your family and friends?	YES/NO
Do you ever lie about gambling, or about the money you have won or lost from gambling?	YES/NO
Do you ever argue with your parents over gambling?	YES/NO
Do ever feel depressed, lose sleep, or feel guilty about money you have lost gambling?	YES/NO
Have you ever considered suicide as a way to escape your problems?	YES/NO
Does one or both of your parents gamble?	YES/NO

Self-scoring guide:

3-4 Yes: Time to wonder if your gambling is getting out of hand.

5-7 Yes: You are losing control over your gambling.

More than 7 Yes: **Seek professional help for what is clearly a problem.** Check your phone book for the number of your local Gamblers Anonymous, or talk to your parents, a school counselor or teacher.

The Brown University **Child and Adolescent Behavior Letter**

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Prepared by Mary-Kim Arnold, editorial assistant.

Violence

APA report: Without intervention, violence begets violence

Witnessing excessive fighting in the home, seeing parents lose their tempers easily and being exposed to violence in the neighborhood while growing up are harmful to children even if they are not the direct victims. These circumstances put children at greater risk for becoming victims of violence or participating in violence later on, says the American Psychological Association's presidential task force on violence and the family in its new report. Living in poverty, having easy access to weapons and accepting violence as a way to solve problems are also risk factors to later violence.

Without intervention, violence seems to perpetuate itself throughout the life span, say the experts. It can start with the abuse of a child, who might later abuse a dating partner, then a spouse, and might even end up being abused in old age by his or her own children.

Besides the different influences that can lead to later violence, according to the task force report, growing up with violence can have other consequences, including substance abuse, emotional disorders, poor achievement in school, aggressive behavior, serious injuries, health problems, suicide attempts, separation and divorce, physical and mental disabilities and other aftereffects lasting many years beyond the original violent incidents.

A common dynamic of family violence, according to the task force, is that in most cases the "perpetrator misuses power, control and authority and has a history of violence. There is also an increased likelihood of other forms of abuse occurring when one form of abuse already exists in the family — or may occur in the future without appropriate intervention." If a child is being abused by the father, then there is good chance that the father is also abusing the child's mother.

Other risk factors that are commonly associated with the various forms of family violence are: being isolated from the community and extended family; expecting too much from a child or elderly parent; seeing violence in the neighborhood; or accepting that men can exert control over their family members.

Convened in May 1994, the task force of 10 psychologists spent the past two years examining the psychological research and clinical experience of practitioners to explore the psychological factors influencing victims or perpetrators of child abuse, dating violence, partner abuse and elder abuse. The report also examined how often certain forms of family violence occur, the different treatment approaches for child and adult victims and perpetrators and the effects of family violence on the rest of society. Legal and ethical concerns of psychologists who work with families where violence is alleged or has occurred were also addressed.

According to the report, children who experience "multiple acts of violence, or violence of more than one variety, appear to be at a greater risk of continuing the cycle of violence." Children who are neglected and experience harsh, excessive physical punishment and who do not receive emotional support outside the home are the most likely to be violent as adults.

Epidemiological surveys examining the relationship between violence in the family in the home and later involvement with violence have found the following:

- Boys who saw their fathers abusing their mothers are at an extreme risk of using violence in their own homes as adults.
- The likelihood of marital violence increases when one partner had experienced physical abuse and observed violence between parents.
- The stress of caring for older people, criminal activity, alcoholism, lack of empathy and paternal aggression are associated with family violence.

A gun in the home, according to studies cited in the task force report, makes an individual eight times more likely to be killed or to kill a family member or intimate acquaintance; three times more likely to be killed by or to kill someone in the home; and five times more likely to commit suicide or have a family member commit suicide. And, according to the findings by the APA's Commission on Youth and Violence, also cited in the task force report, chronic exposure to viewing violence in the media can increase one's fear of becoming a victim, can desensitize one from violence and can increase one's appetite for becoming involved with violence or exposing oneself to violence.

The report found that not everyone exposed to family violence suffers severe consequences; some seem to be more resilient. Some of the resiliency factors identified by the experts are:

- Psychological "hardiness"
- Experience of more positive than negative behaviors.
- High self-esteem
- Involvement with extended family and those in the community
- Support from teachers and friends
- Family members' participation in mutual and independent ac-

tivities

Even with all the shocking statistics that show how prevalent family violence is, "the numbers still don't reflect all those who are being abused yet fail to come forward, especially women and children from families of color and outside the mainstream culture," the task force says. Underreporting of family violence is common, say the experts, because many people still see family matters as private, fail to see family violence as a crime and many victims fear retaliation from the abuser.

Other reasons for the underreporting of family violence include:

- Family members minimizing or denying abuse in order to preserve the family unit
- Perpetrators' denial of abusive behavior
- Victims' financial or emotional dependence on the abuser
- Inability to respond to the abuse; for example, when the victim is a child or a frail elderly person
- Discounting emotional abuse because no physical signs exist
- Victims' belief that police or service providers will not help or will be unjust or discriminatory (especially among ethnic minority or gay and lesbian families)
- Lack of nearby appropriate services (a common problem in rural areas)

The task force strongly recommends developing prevention strategies to keep family violence from ever occurring. These strategies and programs need to be made available through schools, hospitals, religious organizations and even recreational centers so everyone has a chance to use them if they need them, its members say. To prevent abuse from ever starting, the programs should focus on helping families communicate, resolve conflicts and deal with power and control issues without ever having to resort to violence.

Other important resources needed to keep an already violent situation from escalating are:

- Community programs that have shelters, counseling and therapy for children and adults, both victims and perpetrators; substance abuse prevention and treatment; home visits for high-risk families; advocacy and legal services; and programs that strengthen the bond between mothers and children
- Collaboration among experts to conduct better evaluation programs to determine the effectiveness of the treatment services offered
- Mandatory pre-sentence assessment and treatment for people convicted of violence against a family member
- Training for all teachers and school administrators to be able to detect and intervene in family violence or abuse situations and teach children how to recognize and seek help when they witness or experience family violence ■

$12.1 million award will create national center for violence research

Carnegie Mellon University will get $12.1 million from the National Science Foundation (NSF) to establish a National Consortium for Research on Violence.

The consortium will be a repository for basic knowledge about the causes and consequences of violence, according to Cora Marrett, NSF's assistant director for social, behavioral and economic sciences. "It will not only provide new data, but it will also integrate substantial but fragmented studies, theory and research methods" into a useful body of knowledge, Marrett says. "Until now, there has been no effective mechanism for cooperation among researchers in diverse fields of science to systematically examine this subject, which has prompted so much scientific and public concern."

Carnegie Mellon plans to assemble a team of 39 researchers from 24 research institutions in 11 states, Canada and four European countries.

"Crime, particularly violent crime, has been identified for the past several years as the public's number one concern," says Carnegie Mellon professor Alfred Blumstein, the consortium's director, "yet we cannot be effective in dealing with it without developing a strong base of knowledge about its causes and about the consequences of various kinds of intervention."

The consortium of scientists will look at the development of violence in individuals and try to discover how and why violent patterns develop in some individuals and not others. Related issues will include drug abuse and drug markets, guns, gangs and socialization processes in families and communities.

Some trends are clear. "FBI figures on arrest rates show that armed assault, like most violence, is overwhelmingly a male phenomenon," says NSF's Marrett. "They also show that violence is a youth phenomenon: Both males and females between the ages of 15 and 29 are far more likely to be arrested for armed assault than any other age group. The question is: Why?" ■

What's New in Research

Aggressive, rejected boys suffer poor outcomes

Boys who are both aggressive and rejected by their peers are more likely than either aggressive or rejected boys to have behavioral problems later on, according to a two-year follow-up of 81 third- through eighth-graders. Aggressive-rejected children exhibited more conduct problems and social rejection two years later than boys in the aggressive or rejected groups. The boys were grouped according to behavior observations, teacher ratings, peer ratings and open-ended peer interviews. When aggressive-rejected boys who didn't improve were compared with those who did, continued risk was predicted by a broad array of dysregulated conduct problems, including physical aggression, disruptive-hyperactive behaviors, low rates of positive interactions and low social preference. These findings suggest that being unaccepted and disliked by peers may promote escalations in aggressive behavior and withdrawal from future interactions with peers. By contrast, boys who were rejected but not aggressive were at considerably less risk of long-term difficulties. As a group, rejected boys did not differ significantly from comparison boys on any dimension of adjustment when they were assessed two years later.

Karen Linn Bierman and Julie B. Wargo, "Predicting the longitudinal course associated with aggressive-rejected, aggressive (nonrejected), and rejected (nonaggressive) status," *Development and Psychopathology*, 7:669-682, 1995. For reprints, write to Dr. Bierman, Department of Psychology, Pennsylvania State University, 522 Moore Building, University Park, PA 16803.

Should MCDD be added to the diagnostic manual?

The results of a new study lend support to the need for a separate subcategory of pervasive developmental disorder not otherwise specified in the next edition of DSM. This proposed entry, called multiple complex developmental disorder (MCDD), would be distinguished from autism on symptomatology and on developmental and environmental background variables. Researchers analyzed the charts of 105 children with MCDD, 32 with autistic disorder, 51 with externalizing disorders, and 56 with internalizing disorders, all with an IQ greater than 70. They found a strong correspondence between the classification of the cases by DSM-III-R categories and the subdivision by means of a multivariate cluster analysis. The cluster analysis did not discriminate between children with emotional and disruptive disorders. Children with MCDD and autistic disorder were significantly different on symptom factors, including psychotic thinking and anxiety, aggression, deficient interaction and communication and stereotypes and rigid behavior. The results would have to be corroborated in multi-center trials before any changes would be made to DSM-V.

R.J. Van der Gaag, et al., "A controlled multivariate chart review of multiple complex developmental disorder," *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(8):1096-1106, 1995. For reprints, write to Dr. Van der Gaag, Department of Child and Adolescent Psychiatry, University of Utrecht, The Netherlands.

Nutritional deficiency implicated in schizophrenia

Prenatal nutritional deficiency may play a role in the origin of some cases of schizophrenia, according to a study of people born during a famine in the Netherlands. Researchers compared the risk for schizophrenia in those exposed and unexposed during early gestation to the Dutch Hungry Winter of 1944-'45. They used a national psychiatric registry to determine how many were hospitalized with schizophrenia from age 24 to 48. The most exposed birth cohort, conceived at the height of the famine, showed a twofold and statistically significant increase in the risk for schizophrenia. Among all birth cohorts of 1944 through 1946, the risk for schizophrenia clearly peaked in this exposed cohort.

Ezra Susser, et al., "Schizophrenia after prenatal famine," *Archives of General Psychiatry*, 53:25-31, 1996

Depression is common among teenage mothers

Depressive symptoms are common among teenage girls who are pregnant or who have recently given birth, according to a new study. Stress and social support were important mediators of depression. A group of 12- to 18-year-olds attending an adolescent pregnancy and parenting program reported their depressive symptoms and level of social support during the third trimester of pregnancy and at two and four months postpartum. Stress was measured during the prenatal and postpartum periods. Completed assessments were obtained from 114 subjects at two months postpartum and 108 at four months. A full 42 percent had significant depressive symptoms in the third trimester, with 36 and 32 percent having scores that indicated depression at two and four months postpartum, respectively. Stress levels increased significantly from the third trimester to the postpartum period and were positively associated with depressive symptoms. Reporting conflict with the infant's father was also strongly associated with increased rates of depressive symptoms. But receiving social support from the adolescent's mother or the infant's father, especially in the postpartum period, was associated with lower rates of depression.

Beth Barnet, et al., "Depressive symptoms, stress, and social support in pregnant and postpartum adolescents," *Archives of Pediatrics and Adolescent Medicine*, 150:64-69, 1996.

Commentary

Coaching for conduct and character

By Thomas N. O'Neil

I learned. I learned about myself and my ability to perform. I learned to understand and encourage other people, to emphasize the process of play, to develop confidence and control, to listen, to understand and to love the game and respect others who play it. I learned about what I've heard my teachers and parents and coaches talk about since I was very young. I learned about character and effort and leadership.

These words were written by a 16-year-old sophomore at the end of an athletic season at his school. He and his teammates kept a daily journal that came to represent a significant dimension of the experience of playing a sport. Begun as an experiment three years ago by a somewhat skeptical coach as a method to help improve athletic performance, the process of keeping journals clearly became an essential part of the athletic experience, in ways that both encompassed and transcended athletics.

These players came to believe, through experience, practice, discussion and encouragement from coaches and one another, that each is responsible for his athletic performance. On one level, this may seem both an obvious and simplistic point, but as everyone knows, we are quick to attribute what happens to us to other forces or other people, rather than to our own actions, decisions or resources. This team, however, came to a common understanding about the process of performance that emphasizes preparation, effort, goals, and emotional and physical self-control. The players had a strongly felt sense that they could assume responsibility for all of the dimensions of their performance over which they had control. This belief had significant implications for their capacity to play at a consistently strong level. Far more than that, however, this attitude — psychologists refer to it as "locus of control" — is one of the characteristics of a maturing young adult developing a relationship with the world and the responsibilities that he or she will assume in it.

Every player developed the conviction that he had the opportunity and, indeed, the responsibility, to "lead": to advance and strengthen the collective values, purposes and direction of his team. Leadership was ultimately based not on power or seniority or age but on relationships — encouraging, listening, understanding, influencing and helping. These students came to see leadership as a combination of shared values, a sense of mutual responsibility and strong relationships.

As we teach and coach and counsel, we can also watch our students work and play. We can provide opportunities and encouragement, in and beyond athletics, for them to reflect, struggle over, and express their feelings and goals and question codes of character and conduct. As was the case with one young team, we can also discover what they have come to understand and value about their game, about themselves, about one another and about the experience that becomes a part of who they are and what they believe.

Tom O'Neil is director of college counseling at Middlesex School in Concord, MA.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Directions

Infants are more competent than we thought

By Kim A. Steffgen

Long-held concepts of maturational limitations and the power of conditioning are losing ground to evidence that the very young infant is a rapid and efficient learner. Infants are much more competent than early studies gave them credit for. The common finding today is that babies can do a lot very early. Inquiry into their ability to learn at an early age has led to some astounding findings. According to Carolyn Rovee-Collier, PhD, professor of psychology at Rutgers University, the human being's ability to learn and remember is as intact at birth as it will be in adulthood.

> ***Skills that emerge, such as an infant's ability to crawl, are both a matter of improving and a liberation from physiologic constraints.***

"The human infant epitomizes a successful evolutionary adaptation to the environment. How quickly an infant acquires control over selected aspects of his environment appears to be limited less by ability than by concurrent demands on the infant's behaviors," says Rovee-Collier, president of the International Society for Infant Studies, which meets this month in Providence, RI.

Infants learn what they need to know when they need to know it. The pace of their development has less to do with a deficiency in their ability to learn, and more with the psychobiological

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Inside This Issue

Infants exposed to drugs in the womb have ways of telling you what they need. *See page 2*

What to look for in a toy. *See page 4*

Parents who owe back child support in Minnesota may lose their driver's licenses unless they pay up. *See page 5*

Coming Up:
How to assess an infant

This month's client handout:
How to uncover the natural creative abilities in your child

Child abuse

Family mobility helps explain why abused kids do worse in school

A major reason why maltreated children do worse in school than children who aren't maltreated may be because their families move much more frequently and they change schools often, according to a recent award-winning Cornell University study.

The study found that abused and neglected children move, on average during their school years, twice as frequently as other children. Previous work by the researchers had found that maltreated children do significantly worse in school and have many more discipline problems than children who are not abused or neglected.

"This study not only lends empirical support to anecdotal reports that maltreated children move more frequently, but also that higher rates of mobility are linked with poorer academic performance," says John Eckenrode, PhD, an associate professor of human development and family studies at Cornell's College of Human Ecology.

The study, one of the few case-control research projects in this area that used a large sample and looked at the long-term effects of the different types of maltreatment, was given last year's Robert Chin Memorial Award by the Society for the Psychological Study of Social Issues for being "original and important."

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Neurobehavior

Drug-exposed newborns give behavioral clues to their needs

By Jean Gardner Cole, MS

The behavior of infants who have been exposed to drugs in utero differs from that of non-exposed infants, and the differences change the rules of interaction for the caregiver. Learning to read the behavioral cues offered by these infants is critical to providing them with the necessary support.

Infants exposed to such opiates as heroin or methadone demonstrate very specific signs of neurobehavioral dysfunction as they go through classic withdrawal. Infants exposed to cocaine exhibit somewhat more subtle behavioral dysfunction. However, when these behaviors are clustered into the behavioral parameters of autonomic, motor, state, attention-interaction and self-regulatory ability, a pattern of dysfunction emerges.

A healthy, drug-free, full-term infant usually can make the transition through states of consciousness smoothly. He or she can become habituated to stimulation during sleep, come to an alert state and interact with caregivers and be consoled relatively easily when in an aroused state. He or she also has a sophisticated repertoire of self-regulatory behaviors to use in self-consoling.

But infants with prenatal drug exposure (PDE) often have difficulty with state range and state regulation. Frequently, they cannot adjust to repeated stimuli during sleep, and have trouble attaining deep sleep. They have difficulty making the transition from sleep to waking. When awake, some have a low, dull state of alertness and difficulty sustaining a cry. Others are very irritable and hard to console. They are in a hyperalert state when awake, and appear to have trouble inhibiting responses to stimuli.

PDE infants persistently avert their gaze when presented with visual stimuli, especially animate stimuli. When they experience auditory stimulation, they have a reflexive response with poor inhibition.

Motor differences are evident in tone and movement. Infants with PDE tend to have abnormally high tension in the muscles of their extremities, but have low truncal tone. Their range of motion can be limited and movement patterns jerky. Reflexes are frequently brisk; for example, the foot would be slow to relax after stimulation, with brisk inward curving (Gallant's reflex). This may be due to low truncal tone.

> **Caregivers need to learn to regulate themselves, too, by being sensitive to the infant's behavioral cues.**

Standing and walking reflexes are often difficult to elicit unless the infant is in an aroused crying state. The high tension in muscles and poor state control contribute to the poor self-regulation of PDE infants, placing them at the mercy of the environment and making them difficult to care for.

Infants with PDE frequently have persistent tremors, startles, moderately rapid breathing, color change with mottling and paling and flaring of the nostrils. "Setting-sun" eyes have also been noted in these infants, but usually only in worst-case scenarios.

Infants exposed to opiates who have been medically treated for withdrawal frequently exhibit disorganized behaviors once the medication has been terminated. They often need the reintroduction of maximal developmental support and intervention until they adjust to being taken off the medication. Many infants exposed to cocaine continue to present dysfunctional behaviors through the first month after birth and need developmental support until signs of neurobehavioral dysfunction have abated.

Caregivers need to learn to regulate themselves, too, by being sensitive to the infant's behavioral cues and allowing "time out" periods when indicated. This will decrease over-reliance on maladaptive behaviors and help the infant begin to use his or her own unique self-regulatory behaviors.

Infants with PDE have been reported to have feeding difficulties. When examined, however, most of the problem stems from unwitting overstimulation during the feeding. Quiet feedings with reduced stimulation — such as keeping the lights dim and the environment quiet, firmly swaddling with limbs bent comfortably toward the body, holding the baby in a semi-upright position and refraining from interaction during feeding — will reduce many of the reported feeding problems.

Documenting the infant's behavioral style helps in understanding his or her development: List the baby's strengths, what triggers dysfunctional behavior and how it is manifested. Then a plan to support him or her can be implemented. ■

Jean Gardner Cole is an infant development specialist and research associate at Boston City Hospital and a master trainer in the child development unit at Children's Hospital in Boston.

What's New in Research

Temperament involved in resilience, vulnerability

Preschool children with difficult temperaments display more behavior problems than do children with easier temperaments, particularly when they are exposed to high levels of family conflict and family expressiveness, according to a recent study. This study is one of the first to examine resilience and vulnerability processes among preschool-age children. A total of 145 2- to 5-year-olds were evaluated by mothers, teachers and independent observers. Mothers reported on two dimensions of family functioning: conflict and expressiveness. Teachers assessed the children's temperament using the short form of the Teacher Temperament Questionnaire. Both teachers and independent observers rated behavior problems on the Child Behavior Checklist for Ages 2-3 (CBCL/2-3). Children with more difficult temperaments who were in high-conflict families had the most internalizing and externalizing behavior problems, while children with easy temperaments had fewer such problems, regardless of levels of family conflict. Although family expressiveness is usually considered a positive characteristic, difficult children from highly expressive families were the most aggressive. Children who are distractible, intense and prone to negative affect may be overstimulated by the open expression of emotion within their families, and may respond to the expression of negative emotion in kind, the researchers suggest.

Jeanne M. Tschann, et al., "Resilience and vulnerability among preschool children: family functioning, temperament, and behavior problems," *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(2):184-192, 1996. For reprints, write to Dr. Tschann, Departments of Psychiatry and Pediatrics, CSBS-204, Box 0844, University of California at San Francisco, San Francisco, CA 94143-0844.

Does season of birth play a role in autism?

A Danish study supports previous research suggesting a link between season of birth and autistic disorders. Like three other studies in the field, the current study found that births of babies who later developed autistic disorders peaked in the spring and summer, particularly in March, and dropped off in the fall and winter. The researchers looked up the birthdays of 328 children with infantile autism and other types of childhood psychoses born between 1945 and 1980, and compared them to those of a control population born in the same period. For some years (1951-56, 1963-68 and 1975-80, combined), an excess of March birthdays was found for boys with infantile autism. Among boys with autistic-like disorders born in those years, the greatest number of births was in November, while no seasonality was observed for a sample of borderline cases. Researchers studying season of birth in autistic disorders are hampered by small sample sizes because the autistic syndromes are rare. Nevertheless, their studies raise interesting questions about the possibility of an environmental pathological factor in the etiology of autism and similar disorders. Possible wintertime culprits include maternal viral infections and nutritional deficiencies, which may have an adverse effect on a group of highly vulnerable fetuses. The researchers found only one significant outlier of autistic boys born in 1957. Interestingly, in the same year, the number of influenza cases also shows the only significant outlier in the period they examined.

Svend Erik Mouridsen, et al., "Season of birth in infantile autism and other types of childhood psychoses," *Child Psychiatry and Human Development*, 25(1):31-43, 1994. For reprints, write to Dr. Mouridsen, Department of Child Psychiatry, Bispebjerg Hospital, DK-2400, Copenhagen, Denmark.

New model proposed for chronically ill kids

A distinction between controlled and uncontrolled forms of disease leads to a better understanding of the family's role in childhood chronic illness, according to a study of asthmatic children. The study found significantly more cohesion and structure in the group of 20 families with a child suffering from controlled asthma than among a group of 20 families with a child suffering from uncontrolled asthma. The findings call into question the psychosomatic family model, which posits a causal link between the family characteristics of cohesion, strictness, overprotection and lack of conflict solving, and the child's psychosomatic complaints. The authors, who developed a new model for the study of chronic pediatric illness, argue that family characteristics are often adaptations to accommodate the child's condition. For example, an overprotective family may be trying to guard its child against possible dangers, and an enmeshed family wants to reduce the child's sense of isolation. The authors' "excitation-adaptation model" emphasizes two circular processes: the progress of the illness and the way in which parents and child deal with medication and medical advice, and the factors influencing therapy compliance on the part of the parents, family and child. By studying these factors in connection with the management of the illness, it should be easier to tell whether family characteristics are adaptive or pathological, the researchers say.

Anne Marie Meijer and Louis Oppenheimer, "The excitation-adaptation model of pediatric chronic illness," *Family Process*, 34:441-454, 1995. For reprints, write to Dr. Meijer, Vakgroep Pedagogische Wetenschappen, Universiteit van Amsterdam, Wibanstraat 2-4, 1091 GM Amsterdam, Nederland.

Newborns

from page 1

demands of successive ages. For example, newborns' need to be inactive in order to maintain stable body temperature imposes energy constraints on their explorations and the extent to which they will try to manipulate the environment.

Unlike species that occupy a relatively static environment, human infants must learn the characteristics and contingencies within their environment that are required for manipulation and control. What is learned is not necessarily expressed at the time the information is acquired. Skills that emerge, such as an infant's ability to crawl, are both a matter of improving or becoming more competent, and a liberation from physiologic constraints.

Rovee-Collier posits that the infant's memory doesn't seem to be any different from an adult's. The content of babies' memories, what is important to them, is different from that of adults, who have more complex networking, greater content and language in their favor. Rovee-Collier argues that because an adult may not remember events before the age of 3 years does not mean that nothing was stored during those years. A 40-year-old is just as likely not to remember the name of a seventh-grade teacher.

Conjugate-reinforcement procedures have proved useful in studies of learning in the first year. Rovee-Collier's pioneering mobile studies have shown that 2- to 4-month-old infants will fixate visually novel stimuli for periods as long as 60 minutes. In her studies, two mobile stands are attached to opposing crib rails, with their suspension hooks joined in the center over the crib. A ribbon is looped from the infant's leg to the hook above.

During periods of conjugate reinforcement, the mobile is suspended from the hook, so the infant can produce movement with foot kicks. The infant quickly learns which leg controls the mobile. During periods of non-reinforcement, the mobile is suspended from the second, inoperative hook. Again, the infant is quickly able to figure out when foot kicks are not producing any movement in the mobile.

Rovee-Collier found that infants can even discriminate subtle changes in shape, pattern or color of mobile components.

The more control infants are allowed over their environmental stimulation, the stronger will be their demonstration of learning and memory, Rovee-Collier says. And the richer and more complex the information within the environment, the better the opportunities, not only to learn, but to exercise those behaviors that contribute to successful adaptation.

Infancy research is exploding in the same direction as genetic research, says Rovee-Collier. "We're positioning ourselves to the point where we are just finding out what infants can do, and are now developing techniques to get into the subtleties and neuroscience of infant behaviors." ■

Kim A. Steffgen is a freelance writer in Portland, OR.

Child's play can be key learning experience

B.F. Skinner said that the advantage in learning how to control the world lies in the anticipation of needs before deprivation occurs. But children need more than control; they need systematic learning opportunities. And while toys are key in this process, they should be carefully selected to optimize learning.

"The best toys don't do anything," says Ed Loewenton, a toy maker and child psychology enthusiast who creates simple wooden toys based on the concept that a toy should demand something of the child's imagination. Loewenton's company, Elwood Turner Co. in Morrisville, VT, makes a dumbbell-shaped rattle with four rings constructed from a single piece of wood, and Quarks, in various shapes, potential colors and construction.

"A toy for creative play must be abstract, unstructured and essentially simple in form," he says. "The toy permits the expression of an increasing competence. If a toy is beyond the level of a child's understanding, he may lose interest in it. But if a toy is truly open-ended, it provides the opportunity for more complex forms of behavior as the child matures.

"A toy car or doll is less open-ended in that it constrains the play somewhat because the child has acquired some cultural and perceptual responses to such objects."

Refraining from giving direction to the child in play is paramount to the child's success, both at interacting with the toy and for development later in life, Loewenton says, adding that over-direction can cause a child to lose interest in a toy, or make him feel like a failure at understanding.

"The principal value to a child of an unstructured toy is the power it gives the child to restructure a small and manageable part of his world," he says. "An adult who preempts that power takes away that value."

To optimize growth, a child should learn to do the same thing in many different places, by bringing toys when visiting other people's homes, as well as do many different things in the same place.

Keep Your Eye On

... tests for premature labor.

A simple, in-hospital biochemical test is a better predictor of whether a woman will go into labor prematurely than either her uterine contractions or cervical dilation, new research suggests. The test, which is performed like a Pap smear, indicates the presence of a substance called fetal fibronectin — a glue-like compound that connects the amniotic sac to the inner wall of the uterus during pregnancy. The test, which has been approved by the Food and Drug Administration (FDA), "predicts much better than anything we have now who is likely to develop preterm labor and who isn't," says Jay D. Iams, professor of obstetrics and gynecology at Ohio State University. "Ordinarily, fetal fibronectin doesn't leak out into the birth canal. When it does, it tells you that there's been a disturbance between the uterus and the amniotic sac and that the risk of early labor is there." Iams believes the fetal fibronectin test will reduce human suffering and health care costs by preventing both premature births and unnecessary treatment of preterm labor. *(American Journal of Obstetrics and Gynecology)*

... maternity stay legislation.

Several states are considering legislation that would regulate lengths of hospital stay for new mothers and their babies. An Indiana law, which will become effective July 1, will require insurers to pay for a length of hospital stay recommended by each woman's physician. Similar legislation was introduced by District of Columbia council members last month. But a maternity stay bill introduced in West Virginia failed to pass by March 15, the last day of the legislative session. Published reports suggested that the legislation was defeated by anti-abortion delegates' attempts to amend the bill. American College of Obstetricians and Gynecologists guidelines currently suggest a 48-hour hospital stay after normal births and 96 hours for cesarean sections.

... deadbeat parents.

About 27,000 Minnesota parents who owe back child support received notices last month that they may lose their driver's licenses unless they take steps to pay the back support. The state's Department of Human Services began sending notices to parents who are at least three months behind in their child support payments and have not made a payment in the last month. To avoid losing their licenses, the parents must pay the back support, make a written payment agreement or ask for a hearing to show they don't owe child support. These parents owe more than $160 million in child support. Parents will have the opportunity to have a hearing before a judge before their licenses are suspended. If a license is suspended, a person who makes a payment agreement and pays support will have his or her license reinstated. "The purpose of this law is to encourage parents to pay their child support, not to suspend driver's licenses," says Laura Kadwell, director of the Department of Human Services' child support enforcement division.

... sex education.

A new policy from the American Academy of Pediatrics (AAP) says children with developmental disabilities, like all children, need sexual education. Some parents are reluctant to discuss sexuality with their developmentally disabled child because they have difficulty envisioning the child's sexual role. They also fear their child may be sexually exploited or become pregnant. This fear is realistic, the AAP says, citing a National Center on Child Abuse and Neglect (NCCAN) report that found 36 of 1,000 children with disabilities were maltreated, a rate 1.7 times higher than that for children without disabilities. Maltreatment included physical, sexual and emotional abuse, as well as physical, educational and emotional neglect, according to the NCCAN report. However, the AAP maintains that the best protection from abuse is to educate the child about sex. The academy believes that sexual education must be tailored to each child's specific level of understanding to help the child develop social skills and enhance self-esteem. Such education will enable children to live richer lives and assert themselves in refusing sexual advances, the academy says. *(Pediatrics)*

... HMOs for kids.

The country's first kids-only health maintenance organization has been launched by Texas Children's Hospital. The new health plan will contract with other providers to offer a full range of health care for children, according to Randee Lehrer, president of Texas Children's Health Plan. It will be offered as part of health care packages offered to Houston-area workers and their families. For example, a worker could sign up with one of the large HMOs owned by an insurance company. The adults in the household would obtain their care from one group of doctors, but the children would rely on pediatricians and other clinicians affiliated with Texas Children's Hospital. The health plan, which has received an HMO license from state insurance regulators, has been organized as a taxable, not-for-profit corporation. It is expected to cover 30,000 children by the end of its first year of operation and 50,000 after three years, Lehrer says. *(Houston Chronicle)*

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Maltreated kids

from page 1

Eckenrode and his colleagues matched a sample of 530 maltreated boys and girls in kindergarten through grade 12 with non-maltreated children, all from Elmira, NY, on gender, grade, school and socioeconomic status to analyze the effects of maltreatment on recent achievement test scores, current grades and grade repetitions, and how mobility affected these factors.

They found that mobility helped account for the effects of maltreatment on each of these measures. Specifically, for grades in English and reading, 33 percent of the effect of maltreatment was accounted for by amount of mobility. For test scores and grade repetitions, 15 percent and 19 percent, respectively, were accounted for by amount of mobility.

"We suspect that the high mobility among maltreated children affects their academic achievement through various mechanisms," Eckenrode says. Unstable family relationships and the generally dysfunctional nature of the families associated with maltreatment may predispose these families to move frequently. These families also tend to be more socially isolated and have fewer ties with neighbors and kin than non-maltreating families.

"Increased mobility may further the social isolation of the child and increase the loss of social support from family, friends, neighbors, schoolmates and teachers," Eckenrode says. "Moving may also affect the child's emotional state which could be linked with learning difficulties. Discontinuity in the curriculum and teacher expectations also could be a factor as the child moves between schools, and, finally, the difficulties that parents and siblings experience as a result of mobility may be additional stressors for the child.

"All these factors may reduce the child's sense of control and self-esteem; his environment feels increasingly unpredictable; and stable sources of attachment become less available."

Eckenrode said that the study has implications for policy that could help stabilize the lives of maltreated children by striving to reduce the number of unnecessary school transfers. He also recommends special programs that target support to highly mobile students because they would likely benefit maltreated children disproportionately.

Eckenrode's previous analysis with the same sample in 1993 found that while neglected children do significantly worse academically than other children, physically abused children have the most disciplinary problems. Sexually abused children, on the other hand, showed no differences in academic performance or in discipline.

The researchers also found that, in general, maltreated children did significantly poorer than their non-maltreated peers on standardized tests and grades, and were 2.5 times more likely to repeat a grade. These findings persisted even when school, gender, number of siblings, age, place of residence and public assistance status were controlled for statistically. The effects of maltreatment did not differ for boys and girls. ■

Commentary

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cited for urging, with no data to back them, that parents should be wary of kissing and hugging their children! Similarly, Arnold Gesell, who made some commendable advances in understanding stages of development, misguided the field and the public in his pronouncement, also without adequate data, that children who perform "below average" on mental tests in the first months of life will likely perform poorly as adults.

Today's child developmentalists, humbled by their own burgeoning database, are usually more cautious than their predecessors. But the need is there for responsible disclosure of facts about the significance of infant behavior, and about relationships between early experience and later human behavior. Our factual base is far greater than it was a mere quarter of a century ago. The public is increasingly inquisitive about behavior and development. We must help it understand that "statements of fact" are best defended with data, and that the scientific enterprise must be preserved and nurtured.

Lewis P. Lipsitt

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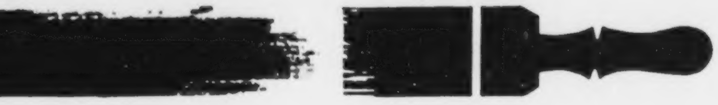

How to uncover the natural creative abilities in your child

by Jane M. Healy, Ph.D.

Creative brains seek out patterns of experience and new ways to put them together. Creativity is the ability to invent, to approach problems with a fresh, unusual perspective. All children are potentially gifted and creative in delightfully individual ways. It's up to parents and teachers to uncover those abilities and help children to make the most of them.

But creativity, by its very nature, is difficult to test. Dr. Paul E. Torrance, author of *Guiding Creative Talent*, has identified four characteristics of creativity:

Fluency — different relevant ideas can be generated about a topic. For example, in two minutes, how many uses can you think of for an empty soda bottle?

Flexibility — different categories or shifts in thinking. For example, switching types of uses for the soda bottle from a container for flowers to a doorstop.

Elaboration — use of details in working out an idea. Embellishing a story plot, for example, or weaving unrelated details together in some interesting way, such as designing a soda bottle with futuristic details.

Originality — creative and imaginative ideas that others haven't had. One student suggested that a gopher could use a soda bottle as a battering ram.

Teachers who have worked to encourage creativity in students add a fifth category:

Evaluation — selecting and refining ideas. Rather than accepting anything that sounds unusual or clever, creative people are ably to apply a filtering process to glean the best or most relevant ideas.

If it surprises you that there has been no emphasis on skill development, you are not alone. However, many researchers who study creativity don't advocate teaching specific skills to young children. In fact, many are concerned that our culture is trying to push children too hard too soon. Instead, they think children should be encouraged to develop at their own pace.

What to look for and encourage

As a parent, you have the unique opportunity to help uncover and foster creativity in your children. However, remember that this is only a general list of broad criteria. Every child is unique in his or her cognitive development, and parents should respect their child's own abilities and developmental rate. The following general qualities indicate creative potential in children, and should be encouraged:

✔ Intense absorption in activities — persistence in working or playing;

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✔ Unusual ability to see patterns and relationships — "Look the legs on the picnic table and benches are all X's, just like the lines on the kitchen floor." "Monique and Abby both act the same way because they are both shy."

✔ Ability to combine things or ideas in new ways — "If I turn the gate on its side, and put it against a wall, it could be a ladder."

✔ Seeing things in a new or different way. "What if the roads moved instead of the cars?"

✔ Tendency to challenge assumptions or authorities because of a well reasoned difference of opinion. For example, a 4-year-old girl dressed her kitten in baby clothes and placed it in a high chair to circumvent the house rules that prohibited animals at the dinner table.

✔ Independent decision making and the ability to take action.

✔ Ability to shift from one idea to another.

✔ Strong intuition — "seeing" answers to problems.

✔ Insightful observations or questions — "What if we see different colors for the thing we both call 'red'?"

✔ Tendency to create and test hypotheses — "I put broccoli in the dog's dish and found out that dogs don't like vegetables."

✔ Ability to tolerate ambiguity while exploring alternatives.

✔ Interest in new ideas.

✔ Enjoyment in thinking and working alone.

Dr. Healy is a learning specialist at the Vail Mountain School in Colorado. She is the author of *Your Child's Growing Mind: A Practical Guide to Brain Development and Learning from Birth to Adolescence*, New York: Doubleday, 1994. To order, call (212) 354-6500.

The Brown University **Child and Adolescent Behavior Letter**

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Prepared by Mary-Kim Arnold, editorial assistant.

Recommended Reading

The Book of David — *Richard J. Gelles. Basic Books, New York, 1996, 200 pages, $23*

The advance praise of this book is itself important, as the advice now offered for the benefit of abused children is different from that once favored: "Gelles sounds a wake-up call to agencies to put children first and reassess the family preservation programs." In April, National Child Abuse Prevention Month, and always, it is important to note that more than 1,200 children are killed by their parents or caretakers each year in the United States. Half are killed after the families have become known to state or local child protection agencies. Gelles, director of the Family Violence Research Program at the University of Rhode Island, has become one of the most prominent spokespersons on behalf of looking after the child's needs first, after becoming disillusioned with the general pattern of welfare agencies to try maintaining intact families at all costs. The cost, Gelles discovered, is too often the child's life. This is a thoughtful and thought-provoking volume.

The World of the Autistic Child: Understanding and Treating Autistic Spectrum Disorders — *Bryna Siegel. Oxford University Press, New York, 1996, 351 pages, $27.50*

The suspicion that something may be wrong comes long before the diagnosis of autism, pervasive developmental disorder or Asperger's disorder. This book, by a founder of the autism clinic at Stanford University and director of a developmental disorders clinic at the University of California at San Francisco, is a comprehensive treatise on the range of autistic disorders, written for child specialists, parents and teachers.

The APSAC Handbook of Child Maltreatment — *John Briere, Lucy Berliner, Josephine A. Bulkley, Carole Jenny and Theresa Reid, Eds. Sage Publications, Thousand Oaks, CA, 1996, 450 pages, $69.95 (hardcover), $32.95 (softcover)*

The collected authorship of this impressive handbook, published in cooperation with the American Professional Society on the Abuse of Children (APSAC), includes such outstanding authorities on aspects of child abuse as David Finkelhor, Byron Egeland, John Briere, John E.B. Myers and Gail Goodman. Not yet 10 years old, APSAC provides all professional disciplines dealing with child maltreatment a knowledge base on which practice with such children may be confidently based. This requires research, and dissemination of findings in a form useful to practitioners. This volume achieves that goal.

Psychosocial Disturbances in Young People: Challenges for Prevention — *Michael Rutter, Ed. Cambridge University Press, 1995, 403 pages, $44.95*

Top experts provide overview of adolescent problems, from delinquency to depression, addressing key questions: To what extent is the problem meaningfully separate from other disorders of the same age group? What are the respective influences of individual, family and societal factors in the etiology of such problems? What are the similarities and differences in the presentation and cause of these problems in childhood and adolescence? To what extent is there continuity between childhood and adulthood, and what are the risk and protective factors? Outstanding authors include David Farrington, Anne Petersen, Bruce Compas, Lee Robins and Albert J. Reiss.

Attention, Memory and Executive Function — *G. Reid Lyon and Norman A. Krasnegor, Eds. Paul H. Brookes Publishing, Baltimore, 1996, 424 pages, $43*

This collection of chapters helps establish common understandings by experts in the critical study of central human functions. The disciplines of behavior science, neuropsychology, special education and medicine examine the distinctions and interrelationships among attention, memory and executive function, and evaluate the tests and procedures used to assess the functioning in individuals with and without disabilities.

Psyche And Eros: Mind and Gender in the Life Course — *Gisela Labouvie-Vief. Cambridge University Press, New York, 1994, 333 pages, $59.95 (hardcover), $18.95 (softcover)*

A beautiful work on historical and current concepts of mind and development, drawing from philosophy, mythology, religion, literature and psychology. The author claims we are taught to develop rational capabilities to the exclusion of imagination. Moreover, the core experience of development differs by gender, with rationality being "masculine" and imagination "feminine," whereas each complements the other.

Female Sexual Abuse of Children — *Michele Elliott, Ed. Guilford Press, New York, 1994, 248 pages, $18.95*

From the foreword: "The subject of female sexual abuse of children has been a dark, unexplored corner of our field ... It is a subject that contradicts everything society holds dear about humankind. It is an assault on fundamental tenets: on our 'motherhood and apple pie' view of the way the world is supposed to be. Exploitation by our primary nurturers ... represents an ultimate betrayal ... " Chapters are by abuse survivors and therapists.

Commentary

Infants: We hardly knew you

By Lewis P. Lipsitt, Ph.D.

Those of us who do research with young children think we have been asking hard questions: What can babies see? Can newborns detect their own mothers by smell? When does a baby become psychologically attached to others? Are newborns capable of classical conditioning like Pavlov's dogs? At what point can we say babies "remember"? Do very young babies really enjoy controlling their own stimulation? Where does the knowledge to avoid falling from heights come from? Does massage have beneficial effects for babies? Are children that have been carried by their mothers most of the day less likely to be hyperactive? Does the style of the caretaker's verbal response affect aspects of speech development in the child? Is sudden infant death less likely in babies who sleep in their parents' bedroom?

Indeed, although we may not have a complete understanding of any of these questions, we do have answers to most of them. In the last 50 years, we have learned a great deal. To put in perspective the growth of our knowledge about baby behavior and development, and the significance of early experience for later developmental outcomes, parallel recent achievements in other sciences must be noted. Science has made possible the telephone, the automobile, the airplane, the computer and spacecraft.

Do we have a "better human product" as a result of the rapidly rising level of knowledge and technological expertise of child developmentalists? Judging by the popular books written, and the presence of so many child development experts in magazines and newspapers and on TV, it appears that we are thought to know a great deal. We are asked if breastfeeding enhances prosocial behavior; whether the father's absence from the home for prolonged periods, or permanently, has adverse effects on the child's development; if homosexuality is an adult condition stemming from childhood experience; and whether meanness and aggression in children are related to parental behaviors in the first years of the child's life.

We are not nearly as knowledgeable about, or as handy with answers to, these kinds of questions as we might be. The behavioral and human development sciences simply have not had the awesome trust and longtime financial support from which other "basic" sciences like biology and chemistry have benefited.

But professional neglect has not been our only handicap. There is history. The field is saddled with a legacy of disrepute and disrespect, born of premature and often ill-conceived pronouncements by the experts, on hot human development issues. The public wanted to know, and our intellectual forebears told them. Developmental behaviorist John B. Watson cannot be faulted for the public misunderstanding, 70 years ago and continuing to the present day, of aspects of his behaviorism. He never said that "all behavior is learned," and he didn't believe it. But he and the eminent pediatrician Emmett Holt can be negatively

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Let research inform our design for youth residential care

By Patrick C. Friman, PhD

Some powerful people are serious about resurrecting large-scale orphanages as a solution to the expanding youth problems in this country. Some equally powerful people are seriously opposed to orphanages.

The pro side has chosen the movie *Boys Town* for its leitmotif, and the con side has chosen the Dickens novel *Oliver Twist*. Although both accounts are poignant and compelling, they are fiction and are thus inadequate to the task of settling the debate or directing effective policy. However, a more empirically based source of information can be obtained from the actual study of residential care for out-of-home youth.

There are not enough adoptive and foster homes to go around. Residential programs are needed. How these programs should be designed and run is critical.

Approximately 65,000 children live in residential care in the United States, and the number is rapidly growing. Currently, American sentiment toward these placements appears skeptical at best and sometimes actually hostile. These negative sentiments stem largely from publicity that followed books and civil court cases that reveal execrable conditions in some older institutional programs.

Children in these older facilities often received inadequate, negligent or no treatment. They were alienated from friends and family, preyed upon by deviant peers and abused by staff. Their lives were beset by a sense of helplessness and hopelessness. Child welfare advocates were legitimately outraged and

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Inside This Issue

Female gang members are being arrested for violent crimes, as criminal activity among this group escalates.
See page 4

Two-thirds of all inmates convicted of rape or sexual assault have victimized children.
See page 7

Meanness is destroying or disrupting the lives of millions of people, and meanness is behavior.
See page 8

This month's client handout:

Know the facts about managed care before you enter treatment

Youth advocate: Public fear threatens groundbreaking juvenile-justice law

Reported By Gary A. Enos

Congress's 1974 passage of the Juvenile Justice and Delinquency Prevention (JJDP) Act represented a dramatic turning point in combating delinquency and reaching out to troubled youths. It took a system that offered few options for managing young offenders and set aside federal funds for community-based alternatives to incarceration.

More than two decades later, amid media reports of soaring rates of youth violence and the accompanying public fear, supporters of the act worry that Congress will weaken the law and create unintended problems in the criminal-justice system.

"The act is probably our best hope for accomplishing things," says Gordon A. Raley, executive director of the National Collaboration for Youth, a coalition of national youth-serving groups such as the Boys and Girls Clubs of America and the YMCA. "The 'get-tougher' approach is probably going to make things worse, not better."

Congress has begun hearings to reauthorize the JJDP law, and changes clearly could be in the offing. At a March hearing before the Senate Judiciary Committee's Subcommittee on Youth Violence,

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Orphanages

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corrective action was taken. Unfortunately, the problems received far more publicity than the subsequent attempts to repair them.

The family-type revolution

In the past 20 years, a virtual revolution has taken place in residential care. Prominent, nationally disseminated residential programs have advanced from the traditional training school/institutional format with mostly custodial shift-work staff and moved to a smaller group-home format with a family-type atmosphere and highly trained staff who live with the youth. Scientific studies of several programs have shown that youth generally enjoy their placement, learn new skills and improve on a variety of behavioral and psychological measures. Researchers at Boys Town recently reported very positive results from an eight-year longitudinal study.

Boys Town, one of the most widely known residential programs in the world, uses the Family Home Program, a version of the Teaching Family Model pioneered by Montrose Wolf. The study included two large matched groups of youth, one that came to Boys Town and the other that applied, was accepted, but whose caretakers opted for other community alternatives prior to admission. The results showed that, compared to the treatment-as-usual group, the Boys Town group had a significantly higher rate of high school graduation and sense of personal control, they made better grades, established more plans for college or post-high school training, felt less isolated from friends and families, had better relationships with supervising adults, and received more therapeutic services. These group differences developed while the Boys Town sample was in placement and were maintained throughout the entire course of the study, long after youth had departed the program.

The Boys Town group had a significantly higher rate of high school graduation and sense of personal control.

Post-placement problems

Virtually all research on family-style residential programs has shown that youth improve while in placement, but not all the research on post-placement performance has been as positive as the Boys Town studies. Two major studies conducted on the Teaching Family Model in the mid-1980s showed that at two years follow-up, positive within-program changes began to wash out, especially on critical variables such as arrest rates.

This limited maintenance has puzzled researchers, but recent research from the Oregon Social Learning Center may shed some light. These researchers have shown that membership in deviant peer groups is a determining factor in the development and maintenance of antisocial behavior and arrest records. Few residential programs have well-developed aftercare components, and thus most are unable to prevent youth from entering deviant peer groups following program departure. It is possible, therefore, that poor post-placement performance may stem from deviant peer group influence. Clearly, this is an area for additional research.

A need for treatment

Another issue that has within- and post-placement implications is the psychological makeup of youth at admission to residential care. No psychological assessments of youth in the early institutional programs were reported and presumably few, if any, were conducted. Today, youth entering care are typically described with vague, nontechnical terms such as delinquent, troubled or neglected. Although these descriptions are informative for lay, social welfare and perhaps even sociological perspectives on placement, they contribute little to effective treatment planning.

Two lines of recent research help clarify the importance of this issue.

One line is again from Boys Town, which has been evaluating the Diagnostic Interview Schedule for Children (DISC). Developed by the National Institute of Mental Health, the DISC is a highly structured diagnostic interview that can be used to determine if youth meet criteria for any DSM diagnoses.

Results from more than 1,000 interviews show that youth at Boys Town are not just the homeless waifs depicted in the *Boys Town* movie. The average youth meets criteria for at least three DSM diagnoses and displays a pattern of psychiatric symptoms not significantly different from a comparison group completing the DISC in a psychiatric hospital. On the basis of preliminary findings, Boys Town has begun modifying treatment programs to meet heretofore unknown clinical needs, especially in the area of anxiety disorders.

Nurturing needed

The second line of research is from a study of four Positive Peer Culture programs (PPC emphasizes partial or whole peer mediation of treatment for youth in placement). The results show that youth who were beset (had high levels of anxiety and depression) fared significantly worse during and following placement than their less anxious and depressed cohorts, unless the beset youth had regular contact with nurturing, authoritative adults, something that may not be possible in a large orphanage.

Other important issues involve social density of programs and social interactions between staff and youth. A collaborative study between Boys Town and the Oregon Social Learning Center showed that for every youth added to a residential home, the daily rate of behavior problems increased by one per youth. These findings support arguments for small numbers of youth under one roof and are contrary to arguments for large orphanages.

Regarding social interactions, a recent Boys Town study examined the ratio of positive-to-negative interactions between supervising adults and highly troublesome resident youth. The findings showed that when these interactional ratios increased above 5-1, individual youth behavior problems decreased by an average of one per day. These findings support arguments for a high rate of positive interaction between adult staff and resident youth, something that might be difficult in a large orphanage.

Although informative, these developments are too few and too far between. The population of youth needing out-of-home placement is increasing at an alarming rate, and the prospect of large-scale orphanages is growing more real every day. It is time for those who care about our nation's displaced children to face a sobering fact: There are not enough adoptive and foster homes to go around. Residential programs are needed. How these programs should be designed and run is critical.

Unfortunately, the related debate is still influenced by the sins of the past and thus the question debated is often whether we should have such programs and not how they should be designed and run. Arguments drawn from residential research, however, could help remove large-scale orphanages from the equation and perhaps assuage those opposed to residential placement.

At this point, the research shows that nurturing, live-in, adult staff, family-style arrangements, low youth-to-staff ratios, high rates of positive interactions between youth and adults, psychologically informed treatment planning, ongoing evaluation and formalized aftercare plans are critical aspects of effective residential care.

We have come a long way from the world of *Oliver Twist.* Although we still cannot guarantee those youth who leave placement will become productive members of society, we can provide them with a safe, nurturing and therapeutic environment in which to spend the displaced years of their youth.

Patrick C. Friman, a psychologist, is director of clinical services and research at Father Flanagan's Boys' Home, Boys Town, NE 68010.

Speaking of Books

Women's Ethnicities — *Karen F. Wyche and Faye J. Crosby, Eds. Westview Press, Boulder, CO, 1996, 224 pp., $59.00*

A frankly feminist volume, variations among individual women are the theme. Seventeen women psychologists address the effects of the assumption of "sameness" of women and explore diversity. Dilemmas of gender and ethnicity are discussed, with many ethnic communities represented and issues of parenting and education explored in depth. Wyche is a professor of education and Afro-American studies at Brown, Crosby a professor of psychology at Smith.

Disorders and Dysfunctions of the Self and Emotion, Cognition, and Representation — *Dante Cicchetti and Sheree L. Toth, Eds. Rochester University Press, Rochester, NY, 1994 and 1995, 400-plus pp, $71 each*

The fifth and sixth volumes in the landmark Rochester Symposium on Developmental Psychopathology series, these books continue with outstanding chapters on aberrations in self-development, and on the roles of emotion and cognition in the emergence, course and psychopathological sequelae of risk conditions.

Maternal and Child Health Practices, Fourth Edition — *Helen M. Wallace, Richard P. Nelson and Patrick J. Sweeney, Third Party Publishing, Oakland, CA, 1994, 886 pp, $39.95*

This book is impressive in size and impressively reasonable in cost. With a foreword by the eminent pediatrician Julius Richmond, the volume is a collection of exquisitely written, succinct and useful chapters on about 85 important topics, by experts on each of them, relating to maternal and child health.

It Isn't Fair! Siblings of Children with Disabilities — *Stanley D. Klein and Maxwell J. Schleifer. Bergin & Garvey, Westport, CT, 1993, 200 pp., $42.95*

A more vital and challenging task than parenting an essentially healthy child is parenting a child with a disability. The task is especially daunting when there are other children with whom the parents must share their time, energy and love. Non-disabled siblings may come to wonder if they are being treated fairly. The authors share in this volume the wisdom of two decades of publishing the magazine *Exceptional Parent*, from which they have learned about siblings' grapplings with frustration, powerlessness, jealousy, guilt and

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genuine worry about their "special" siblings.

Deferring to their disabled siblings has often caused them to create a wall of silence. In these pages, parents offer their own experiences and perspectives. The parents speak to the importance of sharing experience within the family, and the very experienced editors include their own professional commentary. This is a valuable volume for anyone providing professional help to disabled or otherwise-abled youngsters and their siblings and parents.

The editors of *Exceptional Parent* recommend other readings for parents and caregivers dealing with children in jeopardy, and these can be ordered by calling the magazine at (800) 247-8080:

- "When Your Child Is Seriously Injured: The Emotional Impact on Families," single copy, $4.50.
- "When Your Child Goes to School after an Injury," $7.50
- "When Young Children Are Injured: Families as Caregivers in Hospitals and at Home," $7.50.

A year's subscription to *Exceptional Parent* can be ordered for $24 by calling the same 800 number.

What's New in Research

Serious crime up among female gang members

Female gang members are becoming more violent, and serious criminal activity among this group has risen dramatically, according to a study compiled from interviews with gang members at a Texas residential treatment center. The study cites statistics indicating that arrests of female gang members for violent crimes increased by 393 percent between 1960 and 1978; arrests of male gang members in the same period increased by 82 percent. The 15 young women interviewed for the study represented several gangs in Texas and New Mexico and had been arrested one to six times. The appeal of gang membership, the study suggested, is the sense of "belonging to a family," as well as power, protection and respect based on the fear the gang inspires in others. But along with those feelings come the fear of retribution from rival gangs. Many female gang members also said they feared violence and sexual abuse from members of their own gang. Young people who associate with gangs usually do so by the age of 11 and drop out of school by 10th grade, suggesting that gang prevention programs must start with elementary- and middle-school students.

Christian E. Molidor, "Female gang members: A profile of aggression and victimization," *Social Work*, 41(3): 251-257, 1996. For reprints, write to the National Association of Social Workers, 750 First St. NE, Suite 700, Washington, DC 20002-4241.

First biological child changes outlook of stepparents

A study of 139 stepparents indicates that parents derive no less satisfaction from raising stepchildren than raising biological children — unless the child is the first born to one of the parents. Many stepfathers reported that, upon becoming biological fathers for the first time, they experienced a decrease in satisfaction with raising stepchildren. This predisposition toward the first biological child had been observed in mothers before, but not in fathers. If both parents had children from a previous relationship, having a child together resulted in no change in parental satisfaction. Stepmothers reported finding it more difficult to raise stepchildren than their own children, as measured by such factors as the amount of time spent with the children and the level of discipline required. Stepfathers reported the same difficulties, but not to the same extent that stepmothers did. Researchers say more study is needed on how the difference in parental satisfaction affects the children or the stepfamily as a whole.

William MacDonald and Alfred DeMaris, "Parenting stepchildren and biological children: The effects of stepparents' gender and new biological children," *Journal of Family Issues*, 17(1): 15-25, 1996. For reprints, contact Kelli Whitlock at (614) 292-9475 or at this e-mail address: whitlock.13@osu.edu.

Some young women benefit from breast-reduction surgery

Research suggests that teenage girls who have breast-reduction surgery to ease the physical and psychological pain of larger-than-normal breasts are satisfied with the procedure as adults. Surveyed about six years after surgery, 94 percent of a group of women said they would make the same decision again, as they reported less back and neck pain, more self-confidence and better athletic performance. Researchers say teenage girls with oversized breasts tend to be more self-conscious and have more socialization problems than do older women with the same problem. The research team found little evidence of major problems with physical side effects from the surgery, suggesting that fears about having the surgery done at too young an age are unfounded. Resolution of psychological problems and physical-activity limitations related to large breasts seems to outweigh any complications such as scarring, sensory loss or problems with breastfeeding.

James D. McMahan, MD, et al., *Annals of Plastic Surgery*, 35(3): 227-231, 1995. For reprints, contact Dr. McMahan, 3814 Olentangy River Rd., Columbus, OH 43214.

Know the facts about managed care before you enter treatment

by Chris E. Stout, Psy.D.

Many of us have heard a lot about managed care lately, but it is often difficult to get a clear picture of what it is, how it works, and how it affects your insurance coverage for psychotherapy, diagnostic testing, or medication evaluation.

Managed care is a system of service delivery that involves a network of care providers who have contracted to work for a certain fee. These organizations have various mechanisms in place to review your care and progress, and to ensure that you get the appropriate levels of treatment.

Know your plan

Managed care plans are designed in several ways. In health maintenance organizations (HMOs), if you want your insurance to cover your care costs fully, you are required to see a provider within the HMO network. In preferred provider organizations (PPOs), and point-of-service (POS) plans, you can see a provider outside of the network, however, you probably will have to pay a larger share of the costs.

For example, if you choose to see a provider in your PPO network, you may not be required to make any copayment for many types of services. If you do have to make some out-of-pocket payment, it probably will be only a small percentage of what you normally would have to pay. If you choose to see a provider outside of your PPO network, you can do so, but you may have to pay a greater portion of service charges (commonly 50% or more).

Very few of us take the time to review our insurance plans with a fine-toothed comb when we receive them. However, it is a good idea to review these materials before a crisis or emergency arises. If any part of the plan does not seem clear to you, be sure to ask your employer, or your insurance provider for clarification. This is part of their job, so don't be shy about asking for their help. It is generally much easier to talk to someone than to struggle through "insurance language."

Remember, in today's health care market, you have much more responsibility than in the past. It is up to you to make sure that you understand your benefits.

Know your providers

Many plans will provide you with a directory of approved behavioral health care providers with their location, phone number, and specialty listed. This directory can be extremely useful for selecting your provider. It is important to be an informed consumer in all purchase areas, and health care is no exception.

Telephone potential therapists and ask them about their clinical approach (directive, nondirective, supportive, *etc.*), orientation (behavioral, psychodynamic, humanistic, *etc.*), familiarity in dealing with individuals who have had similar problems to yours, and so forth. Doing this can go a long way in help-

Continued on following page . . .

. . . *Continued from previous page*

ing you to feel informed, and more comfortable with your provider.

When seeking psychotherapeutic services, most plans require that you get authorization before receiving care. Usually, there is a phone number to call, and from your response to a number of questions regarding your situation, an approval decision is made. Typically, authorization is based on your level of functioning. The more severely your condition interferes with your day-to-day functioning, the more likely it is that your treatment will be approved.

Here are some tips on how to keep the process of receiving coverage for your behavioral health care costs as simple as possible:

- Carry your health insurance card with you at all times.
- Make a photocopy of your insurance card and keep it in a safe place in case you lose the original, and need the information before you can get a replacement.
- Become familiar with your benefits package before an emergency arises.
- Use network providers.
- "Interview" potential providers.
- Call for authorization before receiving nonemergency care (and emergency care when possible).

As with most types of insurance coverages, all plans are slightly different. For specific information about your plan, contact your benefits manager, human resources director, or your supervisor.

Dr. Stout is senior vice president of Clinical Applications, Policy, and Development at Forest Health Systems in Des Plaines, IL.

The Brown University **Child and Adolescent Behavior Letter**

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Prepared by Mary-Kim Arnold, editorial assistant.

Juvenile justice

from page 1

state officials testified that Congress should consider loosening some of the act's mandates concerning management of troubled juveniles.

To be eligible for formula grant funds under the JJDP Act, most of which pay for community-based interventions, states must:

- Remove from secure confinement all juvenile "status offenders," or those who commit acts that would not be considered offenses if committed by an adult, such as truancy or running away from home.
- Ensure "sight and sound" separation of juveniles from adults in detention centers.
- Remove juvenile offenders from adult correctional facilities.
- Address the problem of the over-representation of minority youths in the juvenile-justice system.

State officials say the requirements pose a particular problem in rural states, where law enforcement officials often have to transport juveniles great distances to keep them out of adult facilities. The April issue of the National Criminal Justice Association's *Justice Bulletin* quoted Senate subcommittee chairman Sen. Fred Thompson (R-TN) as saying that the mandates "reflect a Washington-knows-best approach to youth violence" and "date from a time when youth violence was not so prevalent or serious."

Yet Raley argues that despite states' concerns about the federal act's requirements, no state has chosen to opt out of them. Some state officials and members of Congress are using the law as a convenient whipping boy for the increases in youth violence since 1985, he says. He believes that numbers such as the 3,000 persons under 18 arrested for murder last year would be even higher if states were not separating nonviolent juvenile offenders from violent youths, and juvenile offenders from adults.

"If you want to decrease juvenile crime, one way to do it is to get kids who are status offenders out of the company of kids who are serious offenders, because evidence shows that they get deeper-involved in crime otherwise," says Raley. "Another way is to separate all juveniles from adults, because if you don't, the juveniles will go deeper into the system."

> **'Most of the public is afraid of adolescents anyway. We raise them in our families and worry about what to do with them.'**
>
> **— Gordon A. Raley**

Rather than looking at statistics for violent crime to determine whether the JJDP Act is working, Raley suggests that decreases in serious property crimes by youths are more telling; they show that the system is intervening with status offenders before they begin committing the crimes that inevitably lead to violent behavior.

In the years prior to the JJDP Act, youths who committed status offenses either were returned home or, if they didn't have a stable family situation, went into a secure training facility. Today, formula grants under the juvenile-justice law have enabled communities to establish alternatives to the polar opposites of home placement and incarceration.

"People in clinical practice have been able to see a wider variety of kids as a result," Raley says.

Yet the politicization of the juvenile-crime issue has most policymakers these days talking about punishment, not intervention. "I'm afraid kids and violence is an issue that stirs emotions in people," says Raley. "Most of the public is afraid of adolescents anyway. We raise them in our families and worry about what to do with them."

Most states already have made significant changes to their laws governing young offenders, *The New York Times* reported in May. The changes have emphasized punishment and victims' rights over children's interests, with many states acting to place more juveniles in the adult system.

In California, several bills now under consideration would at least double the number of youths who could be tried in court as adults. *The Times* quoted Lisa Greer of the Los Angeles County Public Defender's Office as saying, "We are stepping down a very grim path toward eliminating childhood." ■

What does the future hold?

Nurses and computer wizards to take over health care delivery in the years ahead — so says the lead article in the premiere issue of *Health Care Horizon*, a new quarterly publication from Manisses Communications Group Inc. The editor is Robert B. Whitcomb. The publication is a free service to all subscribers, and copies are available by calling customer services at (800) 333-7771.

Journalist and lawyer Jonathan D. Rockoff covers legal trends in a discussion of patient autonomy in the decision to die. Other items cover cancer in China, Medicare, Medicaid changes and a prediction of an increase in angioplasty procedures.

Health Care Horizon is an exclusive report for decision-makers covering a wide range of trends in health care delivery.

Public Policy

Children's treatment providers seek to bring down barriers

While the prospect of parity for mental health insurance coverage may have brightened many an outlook last month, children's mental health providers say parity does not begin to address the issues and needs of children.

"We can't ignore the fact that the kids in our system who are seriously emotionally disturbed will not fit neatly into a medical definition of traditional health insurance," says Joy Midman, executive director of the National Association of Psychiatric Treatment Centers for Children.

At their annual meeting last month, NAPTCC members discussed ways of forging partnerships with other child-serving agencies. Among their concerns are a growing juvenile-justice population; a Medicaid restructuring process that largely ignores children's needs; and out-of-control foster care placements.

The foster care system has become the basic orphanage structure of America, says James E. Spicer, PhD, NAPTCC president. Providers tell of children who have gone through 40 foster care placements. In the worst cases, the cost for treating those children — often unsuccessfully — rises as high as $500,000 a year.

"Until we include these kids in the total picture, we will not be doing justice to the troubled youth of America," says Spicer, who also is president and chief executive officer of Camelot Care Centers Inc., based in Seminole, FL.

Current accreditation standards for facilities follow a medical model that is of benefit only to children with biologically based disorders, Midman says. For children with emotional disorders, the current system encourages structured treatments and medications the children don't need, instead of more appropriate community supports.

Research now points toward children running into greater trouble at younger ages, suggesting that at least one generation may be lost to problems that have become larger than the systems developed to handle them. "If you don't get them by (age) 5, they're going to be lost," Midman says.

NAPTCC members, often viewed as simply providers of residential treatment, have broadened their reach in recent years to include intensive outpatient care, crisis intervention, in-home services and mentoring.

Budget constraints are pushing both children's mental health and social-service providers away from the traditional staff model, Spicer says. The days of residential structures with a full certified staff are largely gone, with low-staff, in-home programs taking their place. Those programs allow for staff intervention as the need arises, but most responsibility falls with the parent or caregiver, who receives some training but at a much lower level than what a clinical staff would bring.

On the other hand, Spicer says, states and managed care companies increasingly push for unsupervised foster care, which offers the child a no-staff structure. "For many children, that's a disaster," he says.

The mental health field is not the only one that sees the problem, and change is occurring. As interagency collaboration and the move toward more integrated services take hold, residential care will continue to serve as an anchor for the difficult-to-treat child who has a bad family structure or poses a danger to self or others, says Lester S. Keyzer, senior vice president of residential services at Las Vegas, NV-based Community Psychiatric Centers. ■

Reprinted from *Mental Health Weekly*, Apr. 29, 1996, a sister publication of *The Brown University Child and Adolescent Behavior Letter*.

A generation lost?

Statistics point toward growing troubles for America's youth. According to Joy Midman, executive director of the National Association of Psychiatric Treatment Centers for Children:

- The number of children who need mental health services doubles every year.
- The number of juveniles entering the correctional system has doubled since 1988.
- Of juveniles in the correctional system, 30 percent have an emotional or behavioral problem.

And research continues to uncover the disturbing trend toward younger offenders committing serious crimes. A recent study of delinquency in children under the age of 10 in Hennepin County, Minn., which includes Minneapolis, illustrates the extent of the problem:

- Child-welfare workers previously had investigated the families of 81 percent of the children arrested.
- 70 percent of the children had a parent or sibling with a criminal record.
- 91 percent came from families that either were on welfare or had received public aid in the past.

Keep Your Eye On

... disability protections.

Advocates for children with serious emotional disturbances are watching potential amendments to a reauthorization bill for the Individuals with Disabilities Education Act (IDEA), which guarantees the right of students with disabilities to receive an appropriate public education. U.S. Sen. John Ashcroft (R-MO) is interested in giving school departments more disciplinary authority in certain cases regarding children with disabilities. Under an amendment he is preparing to a proposed reauthorization bill, children whose disciplinary problem or criminal act is found not to be causally related to their disability would be subject to the same disciplinary measures as other schoolchildren would. For children whose behavior is found to be related to their disability but who still are considered dangerous, the amendment most likely will propose removing them from school and placing them in an interim educational setting. Sen. Slade Gorton (R-WA) has suggested barring the awarding of attorneys' fees to parents who prove in court that a school violated their child's civil rights unless they also demonstrate that the school acted in bad faith.

... teen suicide.

New Hampshire's suicide rate among teenagers rose to 20 per 100,000 teens in 1995, up from 11 per 100,000 two years earlier. Statistics compiled by New Hampshire's acting chief medical examiner, James Kaplan, indicate that of the 36 teenagers who killed themselves in the last three years, 30 were boys. Kaplan says that since national statistics lag behind the state's, it is difficult to tell whether New Hampshire's numbers run counter to a national leveling-off in the teen suicide rate, last measured in 1992 at 10.8 suicides per 100,000 youths. Twenty-three of the 36 New Hampshire suicide victims in the last three years used firearms. An April conference sponsored by the New Hampshire Youth Suicide Prevention Advisory Assembly delved into several topics related to youth suicide, including domestic violence, depression, sexual abuse and substance abuse. Conference sponsors plan to hold 10 regional training sessions to develop community suicide-prevention teams. (*Associated Press*)

... sex offenses.

The largest prison survey ever conducted shows that of all inmates convicted of rape or sexual assault, two-thirds victimized children. More than half of the victims in these cases were 12 or younger. The U.S. Justice Department study indicates that 88 percent of offenders had a prior relationship with the victim, with one-third being the victim's parent or stepparent. Ninety-seven percent of inmates convicted of assaulting children were male; 70 percent were white; and 64 percent were married or divorced. Of the almost 37,000 children murdered between 1976 and 1994, most were infants under the age of 1. To order a copy of the report, entitled "Child Victimizers: Violent Offenders and Their Victims," write to the Bureau of Justice Statistics Clearinghouse, Box 179, Annapolis Junction, MD 20701-0179; phone (800) 732-3277; fax (410) 792-4358. Cite publication number NCJ-153258.

... rewards in school.

Early research raises concern about a statewide system of rewards for school performance that Kentucky initiated in 1990. The first round of rewards, a pool of $26.1 million, went to Kentucky schools in 1995 as a way to guarantee that schools "shall expect a high level of achievement from all students" and would be held accountable for students' performance. But research indicates that rather than functioning as incentives, the rewards have created bad feelings in many school districts. "The rewards have driven wedges between teachers, parents and schools," says Pam Coe, principal investigator of a study conducted at the Appalachia Educational Laboratory in West Virginia. She adds that the system "created bad feelings among parents, who thought the kids had earned the money, not the teachers." The state's use of student test scores to measure school performance also created problems, ranging from schools' lack of faith in the testing instruments to teachers' engaging in excessive coaching of students with disabilities. (*The Harvard Education Letter*)

Commentary

from page 8

nervous system of humankind have not changed appreciably in hundreds of thousands of years. We do know that behavior is affected greatly by environmental conditions and is responsive to interventions and preventative measures. We must get to know much, much more than we now do about developmental processes, including learning and acculturation, from infancy onward. The final analysis, even of meanness, has to be a behavior analysis.

Lewis P. Lipsitt

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Commentary

Mean adults, mean children

By Lewis P. Lipsitt, PhD

We don't like to confront it, but face it we must. Meanness is extant in the land and destroys or seriously disrupts lives of millions of people. It takes the form of teasing and bullying in children and adolescents; in adults it has the form of character assassination and false accusation. Mean behavior — hurtful behavior that does not appear to be directly retaliatory or defensive — seems most of the time to have self-aggrandizement as its goal and may involve some pleasure-process in relegating another person to a diminutive status. It is, most importantly, *hardly referred to in child development textbooks.*

Disenfranchisement and derogation of selected peoples have been part of the human spirit since the origin of the species. People have long fought over land and property rights, skin color, religion and ethnicity, and "owned relationships." But interpersonal, individualized mean-spiritedness appears unmistakably on the increase, seemingly occurring in ever younger people. This "lowered age of onset" phenomenon has been noted frequently in other troublesome behaviors of the young, such as early drug use, pregnancy and school dropout. Meanness is following the same pattern.

In the past month a 6-year-older (6 years of age!) came very close to murdering an infant, damaging that baby for life. We have learned also of a rampaging car full of teenagers randomly shooting people with pellets, very seriously injuring some who fell off bikes and traumatically scaring dozens of others. Meanness.

Some will say the apparent rise in physical meanness of the young is due to our enlarging population, more crowding, less food, and other reductions in comforting conditions. Everybody is guessing about the causes. The reason for so much guessing is that we are at a very primitive level of understanding human development and behavior. We are where the study of physics was when fire was presumed to have been caused by phlogiston, and when alchemy was popular.

Whatever the presumed cause, there is more meanness around. Some of it may be accounted for by "nuts" gone wild, like the man who shot 16 children and their teacher in a Scotland school. If guns were not so easily available, that carnage might have been prevented. But guns are not the root of the problem, any more than the availability of alcohol is the cause of alcoholism.

Why should we take the nut explanation seriously, anyway? We have a penchant for finding constitutional quirks, insanity or other medical excuses for serious aberrations of conduct in our fellow humans. We say "his mind snapped," or she had a "nervous breakdown." Minds do not snap, and nerves don't break down (not that way, anyway).

When all is said and done about the condition of the human spirit, and when there is nothing left to say or do about the special pleadings on behalf of the nervous system as the origins of malfeasances, we are left with the behavior of individuals. The brain and

(Continued on page 7)

The Brown University **Child and Adolescent Behavior Letter**

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Special Report: International Conference on Infant Studies

Romanian orphans adopted early overcome deprivation

By Sir Michael Rutter, MD

Many have argued that early experiences have lifelong effects on a child's development, and are difficult to alter. Our study of Romanian orphans adopted by families in the United Kingdom does not support that. On the other hand, neither does the research support those who argue that contemporary experiences are all that matter.

The physical environment was variable — sometimes harsh. In many of the orphanages the children were washed by being hosed down with cold water.

Our study involved 166 children from Romania. This report concerns 111 of that group, who were adopted into the United Kingdom before 24 months of age, and who were assessed at age four.

Within this group, we compared those who were adopted before the age of six months and those who were adopted after the age of six months.

Our comparison group is children adopted within the United Kingdom before the age of six months. They were mostly adopted early and came from a mixture of disadvantaged backgrounds, but none as deprived as those in Romania.

The conditions of institutional rearing in Romania were really deplorable. The children were confined to cots, with few playthings. Caregivers talked very little, and there was no personalized caregiving.

Feeding consisted almost entirely of gruel in bottles

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Inside This Issue

Tegretol is approved for use by children under six years of age. *See page 3*

Sports fans' testosterone levels rise and fall with the fortunes of their teams. *See page 3*

Current juvenile law fails to address today's realities about juvenile crime, says advocate. *See page 5*

Early experiences count, such as one that haunts the mother of the alleged Unabomber. *See page 8*

This month's client handout:

Teach safe drinking to your college-bound teen

Bates reveals findings on organization of language in the brain

By Linda Watts Jackim

Language is not organized in babies' brains the way it is in adults' brains. The patterns of brain organization for language that we've learned about from studying adults are built through experience. They are not in that form at birth. So says Elizabeth Bates, PhD, who presented her research at the April International Conference on Infant Studies in Providence, RI.

Historically, the left hemisphere is thought to be the language-related half of the brain. But Bates' research suggests that language is not innate in a specific location in the brain, and that the brain has alternate plans for language development.

"Something's innate, but what's innate is not a little language organ," she says. What *is* innate, Bates believes, is that different slabs of cortex differ in their processing style, in the kind of detail they pull out, in the speed of processing, etc.

"So, under normal circumstances, if you don't have any holes in your head, then the areas that are particularly good at a particular task will win the contract for that job," Bates says. But if that default drive is altered at a time when you are still developing, then other areas of the brain can compensate.

She offers this example of her

(turn to 4)

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Orphans

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with very large nipples, mostly propped up, not held. And the physical environment was variable — sometimes harsh. For example, in many of the orphanages the children were washed by being hosed down with cold water.

At entry to the United Kingdom, half of the children had a body weight below the third percentile, some way below. Others weighed up to the 50th percentile, and there's a mere handful above that. Some were extraordinarily malnourished.

Today, there has been an apparently complete catch-up among those who came to the United Kingdom before the age of six months:

- Their weight now shows a perfectly normal distribution and the physical state of these children is good.
- Their mean Denver quotient score initially was 60. The mean score at four years was about 109, or a mean gain of about 50 IQ points.

Our data suggest that the age of entry, which reflects the duration

One in 16 Romanian adoptees had autistic symptoms

An interesting subgroup has lately appeared in our study of Romanian adoptees: an atypical autistic pattern, often transient, in about one in 16 of the children. From the overall group of 166 children, whose ages ranged up to 42 months at time of entry to the United Kingdom, 11 have been identified as possibly having autism.

Some features expressed by the children were quite surprising. Many were preoccupied with sensations. Seven out of the 11 showed a preoccupation with smell and touch.

Sometimes a child had a focused, circumscribed interest. Two children were fascinated with watches. Another had a fascination with vacuum cleaners, to such a marked degree that before the child visited friends, the parents would call to make sure that their vacuum cleaner was locked away, because if it was available, the child would play with nothing else.

One child had a fascination with new 10 pound notes — not 5 pound notes, not 20 pound notes, not crinkled 10 pound notes — but new 10 pound notes. This child was also fascinated with shiny clothes and with eyeglasses.

So there is quite a range of these striking fascinations, which were intense, circumscribed interests.

I have assigned these children to three groups:

The first child came to the United Kingdom early and made excellent progress. But at the age of about 20 months, she lost language, became socially withdrawn and developed various autistic features. Some six months later, she recovered and is now entirely normal. I haven't the remotest idea what happened to her, but as far as I can see it had nothing particular to do with her early experiences.

Four children had a relatively persistent autistic pattern. One of these has only been seen at four and may actually fit into the third group of transient autistic features. The other three in the persistent group were all unusual in their background in one way or another.

One child was said to have had a 26-week gestation, a birth weight of two pounds and quite a long stay in intensive care. Another child has a severe high-tone hearing loss and was in an orphanage that was notorious for being bad. The third child was reared in unusual social isolation in a single room because of racial discrimination.

This group is atypical in a variety of ways. The three children who were relatively non-verbal have been taught Makaton, an English sign system. What was striking is that they made spontaneous use of this signing — very unusual in autistic children. And in the fourth child there's a good deal of social approach and some sharing of interest, such as bringing things to show the parents.

These children tended to come to the United Kingdom at a somewhat older age, but they weren't particularly remarkable in terms of weight at entry. However, three of the four had cognitive scores below 50.

The transient group all came in somewhat later. The earliest to come was after 12 months, and some came substantially later than that. There is nothing remarkable about their weight at entry. Most had some degree of cognitive impairment in the mildly retarded range, but they show substantial improvement between four and six years of age so that — at least in this group of children — there are important positive changes going on for quite a long time, I mean years, after coming to the United Kingdom

I think it is remarkable that out of this group of 166 children there are one in 16 showing quasi-autistic patterns. This is confirmed with a standardized assessment, and it's far too many to be a coincidence. Its meaning, however, has yet to be determined. ■

— Sir Michael Rutter, MD

of deprivation, is the most important explanatory variable. The weight at entry, which reflects the degree of malnutrition, is a further contributing factor.

The lack of a remaining cognitive deficit in those who came to the United Kingdom before the age of six months suggests that recovery may be possible even after profound deprivation in infancy, though I have to add the caveat that four years is still too early to be sure that there won't be some remaining deficits.

For those who came to the United Kingdom after the age of six months, by contrast, although the catch-up was spectacular and impressive, there was some continuing deficit in the group as a whole.

The question of whether this deficit was a function of their experiences, rather than some pre-existing genetic or other factor, needs to be answered by more research.

What is more difficult to sort out is whether nutritional or psychological deprivation is more important. The finding that the age of entry was strongly predictive even when the weight at entry was below the third percentile suggests psychological and social deprivation constituted a crucial factor.

Insofar as these children show social difficulties, they are more evident with peers and other adults than with parents. This calls into question the early theories on attachment relationships.

In looking at the children's interactions with strangers, an increased proportion showed indiscriminate friendliness. This was more common in Romanian adoptees who arrived after the age of six months.

This is not to say the children necessarily had social insecurity. They didn't cling or appear to lack trust. Rather, the combination of social approach and undue friendliness seems to reflect a lack of appreciation of social boundaries.

The fact that these children still lag somewhat does not support those who argue that contemporary experiences are all. ■

Sir Michael Rutter is honorary director of the Social, Genetic and Developmental Psychiatry Research Center at the University of London's Institute of Psychiatry. He presented this research in greater detail at the International Conference on Infant Studies in Providence, RI, in April.

What's New in Research

Tegretol is approved for pediatric use

Tegretol (carbamazepine), an anticonvulsant drug used in this country for more than 25 years, has received U.S. Food and Drug Administration clearance for use in children under six years of age. Tegretol is indicated as a first-line monotherapy for the treatment of partial, secondarily generalized, and generalized tonic-clonic seizures in children and adults. The medication, which has been proven safe and effective for children under the age of six, is available in scored tablets, chewable tablets and liquid suspension forms. The safety of carbamazepine in children has been studied systematically in clinical trials up to six months. Longer-term data is not available. The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea and vomiting. Although reports of transient or persistent decreased platelet or white blood cell counts are not uncommon in association with the use of Tegretol, the vast majority of cases of leukopenia have not progressed to the more serious conditions of aplastic anemia or agranulocytosis. When initiating therapy with Tegretol, it is important to obtain complete pretreatment hematologic testing as a baseline.

"Established epilepsy drug cleared for expanded pediatric use," *Healthwire*, March 28, 1996. For more information, contact CibaGeneva Pharmaceuticals representative Doug Arbesfeld, (908) 277-5758.

Testosterone levels rise and fall upon winning and losing

Just watching a favorite sports team can markedly increase levels of testosterone, a study reveals. Researchers measured the level of testosterone in the saliva of fans of the opposing soccer teams for the 1994 World Cup. When saliva samples were taken after the championship match, won by Brazil, researchers found that the level of testosterone in the 12 Brazilian fans was 27.6 percent higher than it was before the game. But when samples were taken from nine disheartened Italian fans, the testosterone levels had dropped 26.7 percent from baseline. Three Italian fans were so dejected they wouldn't supply post-match saliva samples. "Testosterone and the feeling of power associated with it increases as subjects bask in reflected glory and decreases as they experience vicarious defeat," the researchers said. They noted that previous studies have found increases in testosterone in athletes and animals who win important events, but decreases in those who lose. The current study determined the same phenomenon exists for spectators as well as participants.

James M. Dabbs, et al., "Basking in glory: testosterone changes among World Cup soccer fans," presented at the annual meeting of the American Psychological Association, Aug. 12, 1995. For reprints, contact Dr. Dabbs, Dept. of Psychology, Georgia State University, Atlanta, GA 30303.

Language

from page 1

theory about the nature of language and innateness: "If you walk down the hall in a high school you've never been in before, I'll bet you can pick out half the members of the basketball team without knowing any of the children. Now how can you do that? Because you know that tall and graceful and agile children are going to be recruited into basketball.

"But you can play short basketball. There's Japanese basketball, right? The point is, that under default and normal conditions the tallest kids tend to be the ones recruited because they lend themselves better to that sport. That doesn't mean they were innate basketball players."

In the same way, Bates says, there are certain areas of the brain that — with all other things being equal — are going to be particularly good at solving the language problem, so they'll take over the task. "By the time you're an adult, its too late to undo it," she says. But if you're a baby, and you have a stroke that causes damage to those areas of the brain, then you will "just put it together another way."

For 15 years, Bates and her colleagues have been collecting data on language development at different stages of life in populations of children who suffered brain damage before language-learning would ordinarily begin. "So these were all — if you will forgive the metaphor — linguistic virgins, when they had these strokes. And they really do tell us about the initial state of the brain in a way that we wouldn't be able to interpret from a child who had a stroke at the age of four or eight or 10."

Bates and her colleagues follow these children through different stages of development, watching them solve the language problem at different points.

She says the location where a stroke occurs in the brain makes a difference. "Different kinds of lesion sites create different patterns of delay in the early stages [of development] that don't look at all like the adult version."

For example, in little kids — but not in adults — right hemisphere damage affects word and sentence comprehension, Bates says. And in little kids, damage to the left temporal lobe, the sensory cortex, makes them slower at production, but not comprehension.

> **"We expected baby brains to look like little tiny versions of grownup brains, and they don't."**
>
> *— Elizabeth Bates, PhD*

"That seems paradoxical," she acknowledges. "Why on earth should sensory cortex slow you down in production?"

Because, Bates says, if it is true that the left side sensory tissues are particularly good at pulling out the little details of language, then it's going to take you a lot longer to pull out the little details if you are a child with damage to the left temporal lobe.

"In order to learn to talk the first time around," Bates says, "you have to do a much more detailed perceptual analysis, because you're going to have to create your first motor template. So in order to reproduce sounds, we really have to pull out the details of what they sound like."

Once you're an adult, that's no longer true. Once you've learned a word, it's already stored. We just pull it out.

"The point is, we expected baby brains to look like little tiny versions of grownup brains, and they don't," Bates says.

That doesn't mean they look like undifferentiated masses. "Different regions are good at different kinds of processing and — if you don't damage the baby — you can pretty much predict, like the tall kids for the basketball team, which regions will end up winning which jobs," Bates says.

Bates stresses that there is an important difference between whether an area *does language* and whether it is a *language area*. "If I damage my elbow," she says, "it's really going to have a bad effect on my tennis game. But that doesn't mean my elbow was a tennis processor. Or if I break my hand, it's really going to mess up my writing. But that doesn't mean that my hand is a writing implement. It can be used to write, but it does a lot of other stuff, too. So, the discovery that an area of the brain participates in language, does not permit you to say it's a language organ."

It's tempting, she says to look at a CT scan study of the brain and say "oh, here's an area that lights up when you play chess. It must be a chess area." Her point is the same as about the tennis elbow. Maybe that area is a much more general processor that is important for saying "now remember this" or "oops, I made a mistake." Areas can be doing very general kinds of jobs, and it may be that your music task or language task required that area, but that doesn't mean its a music area or a language area. ■

Elizabeth Bates is a professor of psychology and professor of cognitive science at the University of California at La Jolla. She is co-author of a book, *Rethinking Innateness: A Connectionist Perspective on Development*, to be published in September by MIT Press.

Teach safe drinking to your college bound teen

by Dwight B. Heath, Ph.D.

It once was a unanimously happy occasion when a high school senior was accepted at the college of his or her choice. But that enthusiasm has been dampened somewhat by reports of sexual assault, rape, violence, and deaths associated with binge drinking on college campuses.

We could blame the media for sensationalizing these stories. Or we could blame the universities, or society as a whole. But none of this will mask the grim reality that too many college students drink too much, and there are serious risks involved in their doing so.

What are you, as a parent of a college-aged student, to do? It may be tempting to warn students about the dangers of drinking, but most adolescents already have heard most of the warnings and even may have seen some of the consequences. A majority already have done some experimenting of their own.

Current research holds that more than half of high school seniors in this country already drink more than once a month. Even if they are not bingeing, they know from the experience of others, that it rarely appears to have lasting consequences. For many teens, the risks can seem to be exaggerated, and the pleasures of drinking certainly are not discussed in health class.

They also know that soon, they will have easy access to beer and other alcoholic beverages (even if they haven't until now) and will face considerable peer pressure to "be sociable," "relax," and "have fun."

Anyone who cares about an aspiring college student should respect that person enough to talk frankly about the risks of excessive drinking, just as they would about the risks of using drugs or of careless spending.

As a parent and longtime member of a university community familiar with drinking problems in many countries, I am convinced that most young people should learn both how to drink, and how not to drink — whether that means declining a drink, avoiding certain places or people, or simply holding a glass for a long time.

For many adults, it can be fun to drink in moderation — with food, with talk, with no intention of getting drunk. There is a rapidly growing body of research that indicates that moderate drinkers (about two drinks per day for males, one drink per day for females) are at less risk for developing cardiovascular disease and have lower death rates from many causes, compared both to nondrinkers and heavy drinkers.

People don't have to drink if they don't want to. We know that individuals vary enormously in their responses to alcohol, and some people should not drink at all. However, college students will have to make the decision for themselves, each time they find themselves in a situation where alcohol is available. They will have to make this decision based on

Continued on next page . . .

. . . Continued from previous page

their own knowledge, experiences, and wants. In light of this, it is critical that parents or guardians equip their college-bound students with some realistic, practical guidelines. I suggest the following:

- Never drink just for the sake of drinking, as a game or contest, or with the aim of getting drunk or forgetting troubles.
- Don't drink on an empty stomach. Eat both before and while drinking.
- Pace yourself. Until you are familiar with your own reactions to alcohol, don't consume more than one drink per hour. One drink can be a 12-ounce can or bottle of beer, a 4-ounce glass of wine, or 1 ounce of liquor in a mixed drink. Remember that carbonated drinks get alcohol into the bloodstream faster.
- Know when to say "when." Monitor your own feelings. Be wary of any changes in mood or perceptions.

Yes, I know that it is illegal in all 50 states to sell alcoholic beverages to anyone under 21. While most college officials do not ignore the law openly, neither do they enforce it very vigorously.

Throughout our history, there has been a love-hate relationship with drink, and it seems unfair to send students off to college without at least some basic guidelines. A few simple precautions may help even the best students to enjoy and benefit more fully from all aspects of their experiences at college.

Dr. Heath is a professor of anthropology at Brown University in Providence, RI. He is scientific advisor to the American Council of Science and Health, and has studied the use of alcohol in various cultures.

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Prepared by Mary-Kim Arnold, editorial assistant.

Advocate says juvenile-justice law must adjust to the times

A University of Rhode Island expert on family violence who has spent the first half of 1996 on Capitol Hill is criticizing youth-service advocates for attempting to block any changes to the federal Juvenile Justice and Delinquency Prevention (JJDP) Act.

While acknowledging that the 22-year-old law's mandates have helped reduce incarceration of status offenders such as truants and have helped protect children from adults in detention centers (see May 1996 issue), URI Family Violence Research Program Director Richard Gelles, Ph.D., says the law fails to address today's realities about juvenile crime.

Gelles says that the law does not respond to a soaring murder rate among a population of teenagers that is expected to rise substantially in the next five years.

All or nothing?

Gelles has been in Washington, DC, working with a Senate subcommittee that is drafting reauthorization language for the JJDP law. Gelles hopes the Senate Judiciary Committee's Subcommittee on Youth Violence can find a reasonable compromise between youth advocates who want no changes to the law and members of Congress who would like to eliminate all of its mandates to states.

The federal act ties the awarding of formula grant funds for community-based interventions to states' meeting several requirements, including "sight and sound" separation of juveniles from adults in detention centers and removal from secure confinement of status offenders (those whose acts would not have been considered crimes had they been committed by an adult).

Deal with violence

Gelles says he has found that youth-service advocates have "dug in their heels" on the mandates. He believes they instead should recognize that it may be time "to declare victory around the mandates and move on" to more pressing issues, such as the growing problem of youth violence.

The JJDP law has not changed in step with today's juvenile offender, who tends to be more violent than the offender of the 1970s, Gelles says. Murders committed by youths ages 14 to 17 climbed from fewer than 10 per 100,000 population in 1985 to nearly 20 per 100,000 in 1994. Demographic trends indicate that by the year 2000, the number of murders committed by this age group will rise from the present 4,000 to between 6,000 and 8,000.

> **"It's discouraging to be sitting here doing reauthorization of the act and have the discourse focusing on the mandates."**
>
> *— Richard Gelles, PhD*

Given the new reality, "It's discouraging to be sitting here doing reauthorization of the act and have the discourse focusing on the mandates," Gelles says.

State officials have said the mandates pose a variety of problems, particularly in rural areas where there are not sufficient facilities to separate young offenders from adults. Gelles says Wyoming has opted out of the formula grant program because the money it would be eligible to receive is less than what it would cost state officials to meet a strict federal interpretation of the JJDP law's mandates.

But advocates such as Gordon A. Raley, executive director of the National Collaboration for Youth, say the mandates are essential to preventing many low-level youth offenders from becoming violent criminals. Raley suggests that recent decreases in juvenile property crimes indicate that the justice system is intervening with many status offenders before they commit more serious crimes.

Change government's role

The Senate Subcommittee on Youth Violence is expected to introduce a JJDP reauthorization bill sometime this summer, though it is uncertain as to whether any reauthorization bill will pass in this year's session of Congress.

Gelles would like to see a new reauthorization law shift the federal government's role from one of funding programs and enforcing mandates to one of disseminating information on what techniques work best when dealing with troubled youths. ■

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Recommended Reading

Risk and Protective Factors in the Development of Psychopathology — *J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nuechterlein, and S. Weintraub (Eds.). Cambridge University Press, New York, 1993, 554 pages, $24.95 (paperback edition).*

A tribute to Norman Garmezy, this is a key work on risk and resiliency in early development, with authors who are former students, colleagues, and other devotees of Garmezy, the father of contemporary research in this field: besides the editors, John Richters, Arnold Sameroff, Thomas Achenbach, Marion Radke-Yarrow, Marion Sherman, Gerald Patterson, Michael Rutter, Alan Sroufe, Byron Egeland, Robert Pianta, Auke Tellegen, Anne Petersen, John Conger, Jack Block, Judith Rodin, Irving Gottesman, Philip Holzman, and Edward Zigler, among others. This is an important volume, suitable as an excellent text on varieties of developmental destinies and their precursors.

Rallying the Whole Village: The Comer Process for Reforming Education — *J.P. Comer, N.M. Haynes, E.T. Joyner, and M. Ben-Avie (Eds.). Teachers College Press, New York, 1996, 224 pages, $21.95 (soft-cover).*

Nearly 600 school communities have been using the Yale School Development Program's approach to change the school environment. This volume, with the originator of the program as senior editor, presents the specific attributes of the changed climate. Prof. Theodore Sizer says: "Dr. Comer starts with child development — each child, one by one — and he insists that the power of schooling arises from the quality of relationships among all the parties affecting each child. There is blood in Comer's process; his is not another icy technocratic 'solution' to education's ills, driven by disrespect and threat. Quite the contrary. (This program) is both insistent and humane, a rare combination. And it works."

Handbook of Pediatric Psychology (2nd edition) — *Michael C. Roberts (Ed.). Guilford Press, New York, 1995, 814 pages, $75. (hardcover).*

Assembled with painstaking care, this compendium of information about psychological aspects of childhood, with entries by well-informed experts, covers the history of pediatric psychology, legal issues, pain and distress management, grief reactions, all kinds of habit disorders, sleep disturbances brain injury sequelae, sexual behaviors of adolescents, psychoneuroimmunology, and much more.

Keep Your Eye On

... Koosh ball therapy

Ronald D. Davis, known for his work in dyslexia, has developed a method of checking whether a dyslexic student is oriented using . . . Koosh balls. He recommends having the student "get on point" and then have the therapist gently toss balls to him or her to catch, "One in one hand, one in the other." The therapist can progress from tossing the balls individually to tossing them simultaneously. When properly tossed, one ball will be on each side of the student's body mid-line. The therapist may then proceed to toss the balls to the side so that student has to cross his or her midline with both hands to catch both balls. The entire "game" will train the student in what being on point feels like. Davis does not recommend using tennis or Ping-Pong balls because of their tendency to bounce. (*The Dyslexic Reader*)

... table talk

After spending eight years taping family dinner conversations in and around Boston, a Harvard research team found that the dinner ritual feeds a child's mind as well as body. Research showed that dinner was a prime time for children to hear vocabulary-building words like "candidate" and "asparagus." Parents also paid more attention to their children's questions at the table. Through analyzing hours of discussions, the researchers discovered that good table conversation was the best predictor of how well a child learns to read. Dinner conversation even surpassed reading to children from an early age as a learning device. Their findings were consistent in both one-parent and two-parent households. *(Boston Globe)*

... the boomerang effect

According to a report by the Senate Committee on the Judiciary, an increase in the population of American children will soon parallel additional violent crimes and drug use among youth. By the year 2005, the number of teens between 14 and 17 years of age should grow 14 percent, with greater growth among minorities. Researchers James Alan Fox (Northeastern University) and Alfred Blumstein (Carnegie Mellon University) attribute these population surges to a "baby boomerang"—"baby boomers" having children. Although violent crime has decreased recently overall, the homicide rate has increased among those under the age of 25. If the rate of juvenile murderers remains constant for the next ten years, juveniles will commit 1,000 more murders in 2005 than today; if the rate continues to rise, juveniles are expected to commit 10,000 murders in 2005. In addition, if current trends continue, drug use among high school students will increase similarly.

... Big Brothers/Big Sisters

Big Brothers/Big Sisters of America, with 504 member agencies nationwide, matches children and teenagers with adult volunteers who agree to meet with their "Little Brother or Sister" two or four times a month for at least a year. According to *Making a Difference: An Impact Study of Big Brothers/Big Sisters*, children who regularly spent time with their Big Brother or Sister over the course of about a year were:

- ✓ Forty-six percent less likely than their peers to start using illegal drugs, and 27 percent less likely to start drinking.
- ✓ Fifty-two percent less likely than their peers to skip a day of school, and 37 percent less likely to skip a class.
- ✓ More trusting of their parents or guardians and less likely to lie to them.
- ✓ More likely to feel supported by their peers and friends.

The study of 959 10- to 16-year-olds who applied to the BB/BS programs in 1992 and 1993 is the first to use scientifically rigorous research methods to assess the impact of a major mentoring program on youths. A copy of the report is available for $7.50 (pre-payment required) from P/PV, (215) 557-4400. *(CDF Reports,)*

... school-based health care

A new study reports adolescents who use school-based health care have more frequent contact with health care providers than those who use traditional health care facilities, regardless of their insurance status. Researchers from the University of Colorado School of Medicine and the Children's Hospital, Denver, conducted a four-year-study of 3,800 Denver high school students who used school-based health care and found more than 90 percent of these students visited a medical provider at least once each year. Nationally, 77 percent of adolescents with health insurance and only 58 percent of uninsured adolescents visit medical providers each year. In addition, almost one-third of students using school-based health services had professional contact with mental health and/or substance abuse counselors, and almost one-fourth of the students used a combination of health services. According to the lead researcher, "The large proportions of students using mental health and substance abuse services indicates a high level of need for these services among adolescents. On a national basis, poor access to mental health and substance abuse services for adolescents is a serious problem." The researchers conclude that use of school-based over traditional health care facilities does not seem to represent overuse, but may signify patterns of use when adolescents have free access to needed services. *(American Academy of Pediatrics)*

Commentary

from page 8

Turning away from the loved person is the child's first manifestation of indignation over perceived rejection and his capacity for engaging in reciprocal rejection. The head-turn and averted gaze were so powerful in this case that the mother remembers it vividly after 54 years from the first year of her son's sad life.

When Ted was four, the Kaczynski's family doctor showed him and his mother the photos of Ted pinned to the bed. Mrs. Kaczynski says, "Ted glanced at it and he looked away. He refused to look at it anymore." Then, she says, she thought, "He's having the same feelings that he had when he was held down that way."

There were other incidents in the Unabomber's young life that caused his mother some alarm, one of them involving his viewing of an animal that he perceived to be in distress, in captivity actually, to which Ted responded by screaming, "Let it go!" This, too, reminded her of Ted's nine-month-old experience. She insists that Ted was never, in her experience, violent, and seems to suggest instead that he was a sensitive, even compassionate person.

These observations make especially poignant our need for careful developmental explorations, of individuals and experiences. Scientific pursuits relating to child development are more prevalent and more sophisticated today than ever before. With increasing knowledge we will not be so reliant upon anecdotal, prescientific observations made retroactively, as here in this instance. At the recent Providence meetings of the International Society for Infant Studies, reported on elsewhere in this issue, many researchers "reported out" their findings from extensive and continuing longitudinal studies, documenting the importance of early attachments and the unfortunate consequences that may sometimes result from breaches in those important relationships. We have miles and miles to go. ■

Lewis P. Lipsitt

Commentary

Early experience — continued

By Lewis P. Lipsitt, Ph.D.

One of the major tasks of child development specialists is to understand the way in which early events in the lives of individuals affect their developmental destinies. The principal "developmental assumption" is that what happens now affects what may or can occur later. The "developmental assumption" is implicit in the work of pediatricians, psychotherapists, educators and probation officers ... and indeed is of paramount concern for, and the source of much guilt for, parents.

In her first interview, granted to the Associated Press this month, the mother of Theodore Kaczynski, the so-called Unabomber, reflected on the conditions of his early life as she tried to understand her son's behavior. Whether she is correct in her analysis or not, her approach is a refreshing departure from the trite, simplistic conclusion that most have come to: "He's crazy."

Of *course* he's something like crazy. But that's the easy explanation, rather like saying after someone commits suicide, "He must have been depressed." Post hoc diagnoses are easy outs. They are gratuitous, seemingly wise assumptions carrying no more information with them than the behavior that one wants to explain.

We need to know, instead, what the antecedent conditions were. The precursors, the causes, are what the child developmentalist is after, both to understand the individual and to understand the psychological processes in general that cause people to do what they do.

The alleged Unabomber's mother says, "I ponder endlessly over it. What could I have done to keep him out of the wilderness? What could I have done to give him a happier life?" She then recalls an episode in her son's life which continues, she says, to haunt her: Seeing Ted, at the age of nine months, tied to a hospital bed, with wild fright in his eyes, as doctors took pictures of an unusual example of hives which caused his hospitalization and isolated him from his mother for a week.

We are reminded here of the work and writings of John Bowlby, the eminent British psychiatrist whose name is synonymous with the study of "attachment, separation and loss" in children. Much of Bowlby's database came from "children in hospital," whose behavior was documented carefully by Bowlby's colleagues.

Mrs. Kaczynski's further recollections are virtually textbook recreations of the primary infantile "syndrome" described by Bowlby and his coworkers at the Tavistock Clinic and Child Study Centre. She says that Ted would not look at her when she arrived for the one weekly visit she was permitted to make, and that this nine-month-older would not look at her when she returned to take him home.

This turning away from the most loved person in the world, by an infant who cannot speak but nonetheless manifests in his behavior that he has been rejected by that person, is the single most striking characteristic that Bowlby cited as evidence of the child's strong attachment to mother, and the fragility of that relationship in the first months of life.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Social Policy

If disconnected too long, lost youths do not recover

Reported by Ed Susman

One-third of America's youth spends at least one year disconnected from society — out of school, out of work, not in the military and not married.

Most of these 16- to 23-year olds will eventually reconnect to mainstream society and go on to become independent adults, says sociologist Brett Brown, PhD, of the Washington, DC-based Child Trends Inc. But about one-third will remain disconnected for three years or more, and will mature into men and women who have problems earning a living, and will flounder in poverty for their adult lives.

> ***A growing number of youths are spending extended periods of time outside of any role that constitutes an element of independent adulthood.***

The consensus at a recent gathering of child behavior professionals is that the nation's education system has the responsibility to become more relevant to youths at risk of becoming disconnected.

"In a successful transition from youth to adulthood, individuals adopt a succession of roles in the areas of school, work and family formation, culminating in their establishment as independent adults," Brown said at a May conference called "America's Disconnected Youth: Toward a Preventive Strategy," sponsored by the American Enterprise Institute, a nonpartisan research firm that deals with child and family issues.

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What to do about your child's sleeping problems

Violence

Survey finds schoolchildren are scared

By Mary A. Buckner, MEd, and Galen R. Elolf, EdD

We are all aware of the violence that grips contemporary society and affects our educational community. To validate that this violence is affecting the lives of very young children, we administered a survey to fourth-grade students. The survey addressed 10-year-old students' experience and perceptions of violence and threats of violence at home, at school and in their neighborhoods.

Results of the survey sound an alarm that cannot be ignored by school districts in any geographical area, of any size or ethnicity.

The purpose of surveying these 10-year-old students was to raise the awareness of all people involved in the lives of young children to a level of action — rather than reaction. Children cannot learn when they are scared.

A total of 408 fourth-grade students in a large south Texas urban/suburban school district were given an 11-question survey regarding violence and safety. The survey included an open-ended question asking the students to draw a gang symbol, if they knew one. Drawings served to validate the survey data. The sample represents 35.9 percent of a total fourth-grade population of 1,136. Slightly more

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Lost youth

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"Many youth experience a misstep or failure in one or more of these areas without being seriously derailed from the path to an independent adulthood," Brown said. "There is concern, however, that a growing number of youths are spending extended periods of time outside of any role that constitutes an element of that pathway.

"These are America's disconnected youth."

Startling statistics

Brown scrutinized studies of more than 4,000 men and women who were followed for 10 years in the National Longitudinal Survey on Youth and found that 10 percent of America's youth were disconnected for at least one year between the ages of 16 and 23.

The rate of disconnection varied by ethnicity and sex: African-American women, 34 percent; Hispanic women, 21 percent; and white women, 9 percent;

African-American men, 23 percent; Hispanic men, 13 percent; and white men, 7 percent.

More than 10 percent of African-American women were disconnected for four or more years — four times the rate for any other group regardless of race or sex.

Brown found that a higher percentage of disconnected youth came from poor families, families on welfare, single-parent families and from families in which a parent lacks a high school degree.

Being disconnected resulted in significant earnings discrepancies when compared to adults who never reported being disconnected. Men who were disconnected for four years or longer had family incomes as an adult of $19,000, while men who were never disconnected had incomes of $40,200. Women who spent four years disconnected had incomes of $15,600 as opposed to family incomes of $42,300 for women who were never disconnected.

Predictive factors

By studying common activities associated with the likelihood of becoming disconnected, researchers found that those disconnected three years or longer were:

- 50 percent less likely to have participated in high school athletics or related activities.
- much more likely to have had difficulties at school: 56 percent versus 18 percent of those never disconnected among men; 36 percent versus 8 percent among women.
- more likely to be imprisoned. Nearly one-third of the men disconnected for more than three years spent time in a correctional facility compared to 5 percent of men who were not disconnected
- more likely to report earlier first sexual activity (both sexes).

> 'Schools still assign far too little importance to preparing young people for careers, especially students from disadvantaged areas.'
>
> *— Robert Lerman*

"From a policy standpoint, the apparent inability of existing programs to help this group once they become disconnected makes preventive efforts an essential strategy," said Douglas Besharov, a resident scholar at the American Enterprise Institute and a visiting professor at the University of Maryland.

Don't lower standards, raise youth

Paul T. Hill, a research professor at the University of Washington's Graduate School of Public Affairs, suggested that many of the problems resulting in disconnection lie with the comprehensive neighborhood school.

"In response to concerns about students' weak basic skills preparation, they have created remedial reading and arithmetic programs," Hill said. "In response to rights mandates and federal categorical programs, they have created special education programs that treat as many as one-quarter of their students as handicapped; in response to falling student interest and increasing chaos in inner-city families and neighborhoods, many have emphasized the therapeutic content of students' experience and made the schools centers for delivery of social services."

Hill said the new programs come at the expense of teaching more challenging and interesting classes — hallmarks of new focus schools. The focus schools, he said, produce students with better connections to a post-high school life with better scholastic achievement scores and a better utilization of industry and business input into the school curriculum.

Robert Lerman, director of human resources policy at the Urban Institute in Washington, said schools have to realize that minimum skills are not enough for success in the business world.

School-to-career programs

He said businesses seek employees with speaking and listening skills; who react positively to criticism; who are team players; who — even non-college hires — can work with computers, and who work with mathematical problems on a daily basis.

"In general, however, schools still assign far too little importance to preparing young people for careers, especially students from disadvantaged areas. Despite the large share of young people working part-time or moving into the job market immediately after high school, most schools ignore the role of the workplace as possible learning environments," Lerman said.

He advocates the development of school-to-career programs that train students, especially those who are disadvantaged by racial or poverty factors, for real-life opportunities.

Gary Walker, president of Public/Private Ventures, urged the conference not to give up on such social programs as the youth service corps, which don't seem to be making a dramatic and long-lasting improvement.

"We have only been experimenting with public policy in this area for 25 years — and our early hopes were understandably naive. It is worth remembering that almost all these programs — for all age groups — had very positive effects while youth were in them and for a short while thereafter," Walker said.

He urged the development of realistic expectations about what each age group can achieve and to stick to the basics: adult caring and guidance, plenty of legitimate things to do in a youth's spare time, and real help in connecting with employers.

"This is the stuff of successful human, citizen and worker development," Walker said. ■

Reported by Ed Susman, a freelance writer in West Palm Beach, FL. For more information, contact the American Enterprise Institute for Public Policy Research, 1150 17th St., NW, Washington, DC 20036; (202) 862-5800.

What's New in Research

Smart children have problems too

Belief in one's abilities has more effect on one's success in school than natural ability or potential, a new study says. The researchers also found that wanting to learn is a better motivation for achievement than external reasons, such as good grades. The researcher asked 77 third- and fourth-graders who scored above the median on the Stanford Achievement Test why they did well in school and how competent they felt at school. She found that students who were uncertain about their ability and who were motivated by external reasons were uninterested in school and declined academically. Students who were certain of their abilities felt more curious and active in their school activities. Lack of confidence in a student's ability predicted a drop in mathematics and social studies grades but not in reading or the language arts. The researcher explains that by the third or fourth grade children have created self-assessments based on comparisons with their peers or on teachers' expectations. She suggests that failing students are not necessarily the only children with problems and that educators should not overlook externally high achievers.

"Children who do well in school: Individual differences in perceived competence and autonomy in above-average children," Marianne Miserandino, *Journal of Educational Psychology*, 88(2):203-214. For reprints, contact the American Psychological Association, Public Affairs Office, 750 First St., NE, Washington, DC 20002-4242; (202) 336-5700.

New objective test detects ADHD

Researchers have devised what may be the first objective test for attention-deficit hyperactivity disorder (ADHD), the most common psychological problem of children. A recent study has found that in 93 percent of cases, computer measures of body movement and attention are a reliable indicator of ADHD. Researchers used an infrared motion analysis system to record the movement patterns of 18 boys with ADHD and 11 normal controls as they performed a repetitious attention task seated before a computer. The system tracked the position of four markers placed on each of the boys' head, back, shoulder and elbow 50 times per second with a high degree of resolution. Test results showed that boys with ADHD were two to three times more active than normal boys their own age and had larger amplitude, whole body movements. Researchers also were able to accurately discriminate 16 to 18 of the boys with ADHD from 11 of the 11 normal controls. The test detects children who know they should sit still and try to sit still but physically cannot. It also enables doctors to rapidly adjust medication to find the dose that normalizes the child's capacity to sit still.

"Objective measurements of hyperactivity and attention problems in ADHD," Martin Teicher, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(3):334-342, 1996. For reprints, contact Dr. Teicher, McLean Hospital, 115 Mill St., Belmont, MA 02178-9106.

Children lose educationally from parents' divorce

According to a new study, children who do not consistently live with two biological parents are only half as likely to ever attend a selective college, even taking into account factors such as income and parent education. The family disruption that a divorce causes has profound negative impacts upon children's standardized scores, results indicate. The researchers analyzed "The High School and Beyond" longitudinal survey of almost 12,000 high school seniors and almost 15,000 high school sophomores initially interviewed in 1980 and re-interviewed in 1982, 1986 and 1992. After controlling for parents' income, employment and education, student's grade point average, SAT scores, participation in sports and other extracurricular activities, and identifying the top 50 colleges in the nation, the researchers noticed striking differences between the two sets of students. The researchers found that 28 percent of students living with two biological parents were likely to apply to a selective college as opposed to 17 percent of students not living with two parents; 2.2 percent of two-parent students were likely to attend a selective college compared to only 1.1 percent of one-parent students. The results suggest that students from divorced homes are educationally disadvantaged to an extent that could have repercussions on the rest of their lives.

"Family composition and college choice: Does it take two parents to go to the Ivy League?" Dean Lillard and Jennifer Gerner, reported at the annual meeting of the Population Association of America in New Orleans, May 9, 1996. For more information, contact the Cornell University news service, 840 Hanshaw Road, Ithaca, NY 14850-1548; (607) 255-4206.

Childhood trauma plagues adults

A recent study supports other research that the effects of trauma experienced in childhood persist into early adulthood. The study examined the relationships between posttraumatic stress disorder (PTSD) symptoms, trauma exposure, gender and diagnostic comorbidity. Researchers interviewed 59 Cambodian young adults (29 male and 30 female) who survived massive trauma as children and some of whom suffer from posttraumatic stress disorder. The researchers found that 59 percent of those with PTSD had one or more additional disorders, particularly major depression and generalized anxiety disorder. Women had higher levels of both current and lifetime PTSD symptoms. The researchers concluded that trauma symptoms were related to exposure and exposure was related to age. Also, survivors of massive childhood trauma are likely to have PTSD and comorbid diagnoses, just like those who survive adult trauma.

"Comorbidity of psychiatric diagnoses with posttraumatic stress disorder in survivors of childhood trauma," J. Hubbard et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(9):1167-1173, 1995. For reprints, contact Dr. Hubbard, Institute of Child Development, University of Minnesota, 51 East River Road, Minneapolis, MN 55455-0345.

Behaviorally disordered are at risk for injury

Research suggests that children with behavioral problems are at considerable risk for unintentional injuries regardless of ethnicity. Researchers performed a cross-sectional analysis of data on 11,630 children in the 1988 National Health Interview Survey. Through stratified and multivariate analytic modes, the researchers studied the relationship between unintentional injuries and behavioral problems among white, African-American and Hispanic children. They found that accident rates were highest in white children (17.9 percent) as compared with both African-American (9.3 percent) and Hispanic (9.3 percent) children. However, overall the odds of accidental injury in children with severe behavioral problems were 1.65 times greater than in children without behavioral problems. Also, ethnicity did not alter the relationship between overall behavioral problems and higher injury rates. The researchers suggest that special accident prevention strategies are needed for children with behavior disorders.

"Relationship between behavioral problems and unintentional injuries in U.S. children," Regina Bussing et al., *Archives of Pediatrics & Adolescent Medicine*, 150:50-56, 1996. For reprints, contact Dr. Bussing at the University of Florida, Health Science Center, Box 100177, Gainesville, FL 32610-0177.

Speaking of Books

PARENTS' CULTURAL BELIEF SYSTEMS — *Sara Harkness and Charles M. Super, Eds. Guilford Press, New York, 1996, 557 pages, $60.*

A rich volume offering a multifaceted view of belief systems of parents from a cross-cultural perspective. Parenting style is a cultural construction, and has consequences for children's well-being and growth, as well as their understanding of "family" and selfhood. A cross-disciplinary collection of chapters by truly excellent writers and researchers, the volume addresses key questions and provides insight for culturally sensitive therapeutic interventions.

GENDER DEVELOPMENT — *Susan Golombek and Robyn Fivush. Cambridge University Press, New York, 1994, 275 pages, $49.95 (hardcover), $16.95 (softcover).*

Very readable, informative, exceptionally well-defended with well-designed psychophysiological, hormonal and behavioral studies, this is said to be the first book to examine gender from a developmental perspective. Addresses the sensitive and complex question of what *really* causes males and females to be different. The book is a must for anyone seriously interested in the roots of gender differences.

What to do about your child's sleeping problems

Many parents are concerned about their toddler's or preschooler's sleeping problems. Some children don't want to go to sleep at all. Others will only sleep in their parents' bed. Still others will go to sleep but get up during the night and crawl into their parents' bed.

Sleep problems can be troublesome, but the following suggestions should help make bedtime easier for you and your child.

To help your child go to sleep:

① Get into a bedtime routine or pattern. This means doing the same thing every night at about the same time, like giving your child a bath, reading a quiet story and giving him a goodnight kiss, followed by bed.

② Avoid exciting games like running or rough-housing before bedtime.

③ Let your child sleep with a toy or blanket if she wants to.

④ If your child is afraid of the dark, leave a light on in the room. Make sure that this light is slightly less bright than the regular light in the room. Then gradually use dimmer and dimmer lights until your child is sleeping totally in the dark or with the use of a night light only.

⑤ After putting your child to bed, say, "Goodnight. I'll see you in the morning." Then leave your child's room until morning.

⑥ Sometimes your child may call you after you have said, "Goodnight," and left the room. Your child may say, "Mommy, I need a drink," or "I forgot to tell you something." When this happens, remind your child that this is the last time you will come to her room that night. After responding once, say, "Goodnight," again, and do not return to your child's room until morning.

Getting children to sleep in their own beds:

① Be sure to put your child to bed in his own bed at the beginning of the night. Don't let him fall asleep in your bed or somewhere else.

② Tell your child, "It's time for sleep now in your bed. I'll see you in the morning." Give her a hug and a kiss, and leave the room.

Continued ...

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③ If your child follows you, take him by the hand and lead him back to bed. Do this every time your child follows you.

④ If your child cries, sit beside the bed for a few minutes. You might try patting her gently. Do not get into the bed with her.

⑤ If you are consistent, and you follow steps 1 through 4 every time, your child should be falling to sleep in his or her own bed within a few weeks.

⑥ If your child climbs into your bed after you have gone to sleep, get up at once and take her back to her own bed. This is hard to do when you are sleepy, but it is very important that you do it every time your child climbs into your bed. If you are unaware that your child has joined you, take her back to bed as soon as you become aware of this.

⑦ Remember, it's easier to keep your child out of your bed if he or she has never slept there.

Source: Dr. Dorilyn English and Dr. Jill Linden, Office of Psychological Services, Delaware Division of Public Health, D.H.S.S., State of Delaware, 1987.

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Prepared by Helen Ebrahim, production coordinator.

Schoolchildren

from page 1

than 48 percent of the respondents were male. (District gender division is 51.5 percent male, 48.5 percent female.)

Ethnicity reported by the students was: Hispanic, 30.4 percent; African-American, 16.2 percent; white, not of Hispanic origin, 44.6 percent; Native American, 2 percent; Asian or Pacific Islander, .1 percent; other, 5.9 percent.

These surveys were administered in the spring of 1994 in the classroom by student assistance counselors following a six-week program that addressed six basic life skills: building self-esteem, enhancing coping skills, managing stress, resisting peer pressure, reinforcing decision-making skills and emphasizing healthy lifestyles. Students were assured anonymity.

Alarming results

We found that:

- More than one-third of these 10-year-olds (37.3 percent) are left at home alone for more than an hour.
- Nearly one-fourth (23 percent) are afraid to walk alone in their neighborhoods.
- Twenty-eight percent knew someone who had been threatened or hurt by someone with a weapon.
- Twenty-nine percent knew someone who was hurt at home by a family member.
- A shocking number, 132 (32 percent), reported drive-by shootings in their neighborhoods.
- Sixty-five percent have seen gang graffiti in or near their schools, and 55 percent have seen older students wearing colors or gang symbols or using gang signs at school.
- Sixty-three percent of those surveyed are afraid that they might be hurt by someone in a gang; 47 percent worry that a friend or sibling might be in a gang.
- When asked if they had been approached while in school to join a gang, 16.5 percent said yes.

A more revealing finding is that, contrary to our expectations, only 53 percent feel safe at school. For years, educators have assumed that elementary schools provide a stable, structured and safe environment for their students. This appears to be the case for only about half of the students surveyed. The other half are afraid: They don't

(Continued on page 6)

How to help keep children safe

Solutions are not simple for a problem of this magnitude, but multiple, comprehensive strategies can minimize children's fear of violence and maximize care and cooperation.

Schools can become true community centers where parent volunteers can direct both creative and athletic activities. School safety plans can include personal safety information that is age-appropriate and does not cause parents to become hypervigilant. Parents can be given lesson plans for helping their children with homework and home management skills. Schools must instill interpersonal problem-solving skills and racial tolerance and then teach multicultural sensitivity. All parents, especially single parents and working mothers, need help. The focus of that help can come from the schools.

Schools must become an inviting place to all parents, even those who may have had negative school experiences themselves or have been dropouts.

Law enforcement can enforce their credo: to serve and protect, especially our youth. D.A.R.E. programs and others are expanding to include gang resistance training.

Clergy can assist in making the school a community center by encouraging members of their congregation to be surrogate siblings or parents and grandparents. Teachers are already serving as surrogate parents; perhaps that role should be extended. Any number of service organizations can, and often do, collaborate with the schools to provide services to students before, during and after school. These efforts can be increased.

Parents should be adults — not best friends — to communicate acceptable survival skills to their children. Now, unacceptable survival skills are being taught to our children by gang-bangers with automatic weapons.

Ideally, children should not be alone at home for prolonged periods. However, if they are left alone, they should be taught how to lock doors and windows and how to answer the telephone appropriately. Parents should be reachable. If kids can program VCRs, they can learn the telephone numbers of trusted friends and relatives or strategies to reach these people if no telephone is available.

Both neighborhood porch light and watch programs do work. Block captains and designated safe houses are also viable.

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feel safe at school, in their neighborhoods or in their homes.

These kids know more about gang signing and graffiti than do their teachers and parents. Forty-seven percent of the respondents were able to draw recognizable gang symbols or hand signs. The most frequently appearing symbol was the "Kingz," followed by "Crip" and "Blood" signs.

Many of us in education have suspected the focus of the fears of our children; now we have evidence to validate our suspicions. This is obviously only a beginning.

We are aware that gang members are moving to more rural areas for many reasons: new drug markets, safety from rival gangbangers, unacceptable behaviors at previously attended schools, naiveté of the community and/or previous police involvements. School districts that were never before affected by these activities are finding that they are, indeed.

Juvenile detention affected

Also affected are juvenile detention facilities. They are unequipped to handle the rapidly increasing numbers of juvenile crimes and escalating juvenile violence. No community is immune to influences that make students come to school afraid and, consequently, not ready to learn.

Children like to ride bicycles, climb trees and play ball. They want to feel safe and happy. They don't benefit from viewing violence on the screen or experiencing it in real life. They should not be hiding in their homes or worrying about being hurt either by strangers or by people they know.

If our adult population feels impotent in the wake of our society's rampant violence, consider the confusion and fear of our children. Unless direct action is accelerated to redirect this violence, in another decade, these children could become the victimizers, and whether they can read, write and do arithmetic may be the least of the problems facing our society. ■

Mary A. Griem Buckner is the at-risk coordinator for the Judson Independent School District in San Antonio, TX; Galen R. Eloff is the superintendent of the Judson Independent School District. For more information about the survey, call Ms. Buckner at (210) 659-9639.

Keep your eye on

... books challenged.

I Know Why the Caged Bird Sings, an autobiography by Maya Angelou, topped the list of the books receiving the most objections in 1995, reports the American Library Association (ALA). The book, popular in high schools, portrays the author's sexual assault as a young child. "Angelou's story is chilling, but it is a story that young people respond to and understand," says Judith Krug, directory of ALA's Office of Intellectual Freedom. "Many adults do not want young people to know that life is sometimes harsh." Other books on ALA's "most challenged" list include *The Giver* by Lois Lowry, *Of Mice and Men* by John Steinbeck, *The Adventures of Huckleberry Finn* by Mark Twain, *The Chocolate War* by Robert Cormier, *Forever* by Judy Blume, *Bridge to Terabithia* by Katherine Patterson, *Catcher in the Rye* by J.D. Salinger, and *More Scary Stories to Tell in the Dark* by Alvin Schwartz. The group logged 740 challenges nationwide in 1995 to books in schools, school libraries and public libraries. "Our research suggests that for each challenge reported, there may be as many as four or five which remain unreported," Krug says. (*School Board News*, Feb. 6, 1996)

... the invisible minority.

In a predominantly heterosexual society, gay, lesbian and bisexual youths suffer disproportionately as they enter adolescence. In a retrospective study, gay men indicated that they became aware of their sexual orientation around the age of 14, while a study of lesbians indicated ages 16 to 19 as their age of awareness. Research supports the assertion that lesbian, gay and bisexual youth are at higher risk for depression, suicide, HIV infection and other sexually transmitted disease (STDs). Anecdotal evidence suggests that these youth are also at risk for alcohol and other substance abuse, as well as pregnancy. A study of 500 New York City youth served by a lesbian/gay youth service agency indicated that 40 percent of the young people reported they had experienced a violent physical attack. Forty-six percent of those reporting physical assaults said that the assault was related to their sexual orientation; and 61 percent of the assaults occurred within the family. In addition, this "invisible" minority has few resources for guidance. A study of 289 secondary school counselors found that one in six thought there were no gay students in their schools and 20 percent believed they were not very competent to counsel gay students. *(Transitions*, spring 1996*)*

... divorce education.

The American Bar Association's (ABA's) Family Law Section recently joined with the Association of Family and Conciliation Courts to set up a Task Force on Parent Education. The goal of the task force is to promote and implement divorce and separation education programs for parents nationwide, thereby minimizing the negative effects on children. Such programs differ from state to state, ranging from mandated education for all divorcing parents in Connecticut and Utah to some states without formal programs at all. Over the past decade, attorneys and judges have become strong advocates of divorce education. "How the parents behave during the divorce proceedings is the single most important element in how the children survive the experience," says Timothy Walker, chairman of the ABA Family Law Section. While studies are ongoing to measure the results and effectiveness of these new programs, many parents report positive feedback from their participation.

... parenting styles.

A new study at the Menninger Child and Family Center will research how children and parents interact and the emotional relationships between them. By comparing families in which a child has serious behavioral problems with families with normal children, the researchers will gather information about the effectiveness of various parenting styles. The researchers hypothesize that when a child has major behavior problems, there are also problems between the child and the parents. The research team hopes that the study will be helpful in understanding parent/child relationships and thus in helping parents interact effectively with their behaviorally impaired children.

... obesity in pregnancy.

A recent study found that obese women are more likely than normal-weight women to have pregnancy complications, but the complications are not associated with the pounds they gain during pregnancy. Out of a sample of 683 obese and 660 normal-weight pregnant women, almost 26 percent of the obese women had cesarean deliveries, compared to slightly more than 9 percent of the normal-weight women. The average weight of the obese women was 228 pounds; normal-weight, 135 pounds. Twice as many infants of obese women required convalescent or intensive care compared to normal-weight women. On average, obese women gained one-third less weight during pregnancy than the other women. The study suggests that a 15- to 20-pound weight gain is appropriate for obese women; lesser weight gains increase the likelihood of low-birthweight infants. (*Obstetrics and Gynecology*, March 1996)

... AIDS advertising.

The Centers for Disease Control and Prevention (CDC) has released a new series of public service announcements aimed at preventing HIV/AIDS infection among young people. A National Cancer Institute study published in the November issue of *Science* confirmed that, as each generation comes of age, there is a substantial increase in the rate of HIV infection. *HIV-related illness is the leading cause of death among people ages 25 to 44.* The ads, which were developed with extensive input and evaluation by young adults, encompass a wide range of messages including promotion of abstinence, the importance of communicating with parents, and the relationship of alcohol use to losing control. For more information about the ad campaign, contact the CDC National AIDS Hotline at (800) 342-AIDS. For information about school programs and policies to address HIV/AIDS and school health issues, contact NSBA at (703) 838-6722. (*School Board News*, Jan. 9, 1996)

... young athletes' weight control techniques.

Many young athletes, ranging from thin, graceful gymnasts to stocky, powerful wrestlers, are endangering their health by going to extremes to control their weight, doctors say.

"We have some evidence that in certain sports these practices are very prevalent," says Gregory Landry, a pediatrician at the University of Wisconsin Medical School. He is a consultant to the Committee on Sports Medicine and Fitness of the American Academy of Pediatrics.

The committee's report, based on a series of earlier studies, was published in *Pediatrics*, the academy's journal.

One earlier study, of 257 high school wrestlers in Wisconsin, found that 36 percent had exhibited two or more types of behavior related to bulimia. In another, of 171 college wrestlers in Indiana, 9.4 percent said they vomited at least once a week to meet weight goals.

The pressure for gymnasts to stay thin has traditionally been a problem, especially for girls and young women obsessed with the myth that their appeal and agility will wane as their bodies develop, says Kathy Kelly, a former gymnastics coach who now is an administrator for the U.S. women's gymnastics team.

"I don't think we point-blank told them in the past that, if you do something stupid and try to shortcut this, if you have any eating disorder problems, you won't be successful in your sport, and that's the absolute worst thing," Kelly says.

She says changes are being made. This year's Olympic hopefuls have been counseled several times on proper nutrition and repeatedly examined by a doctor for nutrition-related problems, she said. *(Associated Press)*

Commentary

Help us end our nation's shame

By Marian Wright Edelman

The morally unthinkable killing of children has not only become routine but is increasing in the world's greatest democracy. We Americans allowed 5,751 children to be killed by guns in 1993—almost twice as many as were killed by gunfire in one year a decade earlier. An American child is killed by gun violence every hour and a half.

Unfortunately, we can't look to this Congress to help us end the violence that is killing our children. The very same week the federal government made available these horrifying new statistics on firearm deaths, the House of Representatives voted to repeal the federal ban on assault weapons. And this Congress not only has failed to fund violence prevention initiatives for children that were enacted as part of the 1994 crime act, it has tried to repeal them.

But Congress' behavior doesn't let the rest of us off the hook. Just the opposite. All of us who care about children must stop waiting for someone else to take the initiative and start doing something ourselves to make our communities safer for children. We ought to be organizing campaigns asking parents to pledge that children in their homes will always be supervised by an adult and that all dangerous objects, including guns, will be kept out of the home, or at least out of children's reach. (I was sick at heart to learn of a recent poll showing that fewer than half of the parents who have children younger than 18 and own a gun keep the weapon safely locked away from children.)

We ought to be auditing our neighborhoods for safety. Most neighborhoods have assets—like libraries and playgrounds—that promote children's well-being. But they also have liabilities that threaten children—like empty lots and abandoned buildings that attract troublemakers. Neighbors can get together to identify and map the liabilities that need to be eliminated, as well as additional, potential assets that can be developed to help children. For example, businesses might be asked to provide internships and summer jobs for teenagers. The audit should become the basis for an action plan to make the community safer for children.

We ought to make sure that children have safe places to go after school, on weekends and during summers. We need to challenge churches, synagogues, mosques, recreation centers and other organizations—especially in unsafe neighborhoods—to open their doors to children and recruit adults to supervise children's study and play and to serve as mentors. Faith communities, especially, should provide leadership, calling on members of their congregations to give more time, attention and moral guidance to children.

We can't depend on others to save our children's lives. *We* must act. Every day that we do nothing, we lose 15 more children to guns. ■

Marian Wright Edelman is president of the Children's Defense Fund, 25 E St., NW, Washington, DC 20001. Her comments are adapted with permission from *CDF Reports*, April 1996.

The Brown University Child and Adolescent Behavior Letter

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Facilities rethink policies on use of physical restraint

By Lu Cribari

Sweeping changes in public policy and a growing consumer movement focusing on patient rights are leading to new thinking on longtime practices of restraint and seclusion, experts say.

While the goal in an ideal world may be to eliminate the use of seclusion and restraint altogether, "It's not reflective of today's world," said Peggy Williams, a clinical social worker who chairs the standards committee of the National Association of Psychiatric Treatment Centers for Children (NAPTCC).

Newly adopted standards by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) call for the creation of physical, social and cultural environments limiting the use of restraint and seclusion to "clinically appropriate" and "adequately justified" situations. But the standards stop short of calling for their elimination (see box, page 3).

Policies and procedures that involve any physical contact with a patient have to be done with extreme care, said Timothy Rivinus, MD, a child and adolescent psychiatrist at Harvard/Pilgrim Health Care Center of New England and a clinical associate professor of psychiatry and human behavior at Brown University.

Treating behavioral disorders in least restrictive settings is a concept born in the civil rights movement.

"Seclusion and restraint may only be used to pre-

(turn to 2)

Vol. 12, No. 8 August 1996

Inside This Issue

The brains of children with ADHD differ from the brains of children without the disorder. Researchers are trying to figure out why.

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Child and adolescent mortality may be down, but these gains are offset by increases in homicide and violence and by poverty and risk-taking behaviors.

See page 5

Ways to instill healthy eating habits to last a lifetime.

See page 6

Coming Soon:
Kids who worry too much.

This month's client handout
Child, adolescent depression distinct from the adult version

Objective test shows promise in diagnosing children with ADHD

Researchers at McLean Hospital in Boston have devised what may be the first objective test for attention-deficit/hyperactivity disorder (ADHD), the most common psychiatric disorder in children. While further evaluation is needed to validate the test, a study published in a recent issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* shows that computer measures of body movement and attention are a reliable indicator of ADHD in 93 percent of cases.

"Diagnoses for ADHD are now based on clinicians collecting information from school teachers and parents. This may not be reliable, and it is certainly not objective," said Martin Teicher, MD, PhD, director of McLean Hospital's developmental biopsychiatry research program and the principal investigator of the study. "Our test proves that hyperactivity is not merely a problem in the eyes of the beholder, but can be objectively and reliably discerned in the frequency, amplitude and pattern of body movements."

An estimated 2 million children (about 3 to 9 percent) between the ages of 5 and 14 are diagnosed each year with ADHD, a condition characterized by inattention, hyperactivity and impulsivity. Clinical diagnoses are based on the presence of a constellation of symptoms in which the child is often restless, inattentive or intrusive.

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Restraint

from page 1

vent harm to self or others," Rivinus said. "It has to be used in a clinically appropriate way that helps teach the young person about ways to manage their emotions, bodies and interpersonal relationships."

Restraint and seclusion have been a lightning rod for criticism, most of it around the potential for abuse.

"With kids and adolescents, caution and concern are even more applicable. It should never be punitive in nature," said Williams, who served on the national committee that drafted the new JCAHO standards. "Physical holding is often comforting and gives a young person a chance to regroup."

In some settings, having the option to use restraint allows practitioners to work with patients who otherwise would have to go to correctional facilities, she added.

If seclusion is used with children, it should be carried out in an interactive, therapeutic setting with an adult present, advised Williams, who is Midwest operations director for Camelot Care Centers Inc. in Palatine, IL. She called the use of psychotropic medication a "danger that needs to be watched." She said, "Sedating may make a child easier to be around, but may not facilitate his or her growth or development."

Treating behavioral disorders in least restrictive and "normalized" settings is a concept born in the civil rights movement of the last 40 years, according to Susan Stevenson, MEd, program director at the Groden Center in Providence, RI, which was founded in 1976 as an alternative to institutionalization. The Groden Center serves children and adolescents with autism and severe behavioral and developmental disorders in day and residential programs, as well as in homes, foster homes and schools.

Stevenson is co-author, with founders Gerald and June Groden, of a behavioral analysis training manual used to analyze patients' challenging behavior. Active in state policy formation, Stevenson says this kind of approach is particularly important in school settings where children are being mainstreamed into regular classrooms.

Staff at the Groden Center are trained in physical restraint (holding) techniques, to redirect behavior and manage the environment, and to use behavioral observation to predict behavior. The center's policy restricts the use of behavioral interventions until antecedent conditions have been analyzed. This and other policies are spelled out in a handbook with a 10-point human rights statement outlining every phase of the Groden program. In addition, a human rights committee and reviewers are part of a checks-and-balances system to prevent abuse.

Camelot Care Centers, which provides a variety of residential, in-home and school behavioral health care services to children and their families in Illinois, Tennessee and Florida, doesn't use

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seclusion or mechanical restraints at all. "It's not part of our philosophy," Williams said.

Instead, the staff is allowed to hold small children. With older children, three people may be required to hold the child, while one or more adults are interacting with the child.

Agency administrators aren't naive about their patient populations. The Taunton Adolescent Family Treatment Program at Taunton State Hospital gets some of the toughest cases in Massachusetts. All of the 13- and 18-year-olds in the program are long-term residents; most are at risk for harm to self or others; and many have been abused or neglected.

"We work with the most disturbed kids in the state," said psychologist Hilary Ziven. Still, restraints are used only to protect the teenagers from hurting themselves or others, and seclusion is not permitted at all.

Under tough state laws, the facility regulates the use of restraint by requiring close monitoring of restrained patients, and by keeping it as short as possible — a few minutes to a couple of hours. In addition, when the frequency of restraints exceeds three in a week or five in a month, an external review kicks in. Patients have to fill out comment forms, and monthly reports, reviews of case studies and committee reviews are conducted every other week.

In practice, restraint is a method of last resort, Ziven said. "It requires people to look in a crystal ball and be able to predict when a violent act is about to happen," she said. "It is supposed to be used when people go over the line."

Adolescents often perceive the possibility of restraint as punishment for their behavior. Thus, a simple reminder that a certain behavior may lead to restraint blurs the line between a safety precaution and an intervention with therapeutic value.

"It's one tool that allows us to interrupt behavior," Ziven said. "It is essential and responsible to help. Letting a kid practice being out of control is what leads to disorder; letting them go on is letting them be sicker."

The Taunton staff first tries other options, such as behavioral interventions, family counseling and incentives, such as favorite foods, with out-of-control teens.

Patients should be warned when their behavior is leading to restraint or seclusion, and they should be prepared for its kind and duration, said psychiatrist Rivinus.

"All clinically appropriate seclusion and restraint has to be framed in a way that is gentle and feels safe, is limited in time and respectful," he said. Rivinus recommends a time-out rule based on age: one minute for every year old, but never more than 15 minutes.

Treating young people who have been physically or sexually abused presents another challenge to practitioners because these patients sometimes invite some form of physical restraint or sexual contact. While it is necessary to restrain a patient's advance, experts advise, it is equally important to tell the patient you understand why they are inviting physical restraint, that they have a choice not to respond in that way, and to debrief the patient after such an incident occurs. ■

A method of last resort

The Joint Commission on Accreditation of Healthcare Organizations has adopted new standards limiting the use of restraint and seclusion to two hours for children and adolescents ages 9 to 17 and one hour for children under 9, for periods up to a maximum of 24 hours. The standards require facilities to justify the use of restraint and seclusion, and encourage administrators to set policies that reduce its frequency.

But they do not apply to "therapeutically holding or comforting of children" or to a time-out, when the child is physically prevented from leaving a room for 15 minutes or less.

The revised standards, which were approved this year by the JCAHO's standards and survey procedures committee and went into effect July 1, are applied across the board to children and adults in hospital, ambulatory and behavioral health care settings. This is the first time the standards have supported a patient-focused framework.

Manage Children's Behavior More Effectively

When teachers and parents are caught in a cycle of responding to problem behaviors after the fact, they aren't disciplining children … children are disciplining them! Now, with *A Practical Guide for Discipline and Behavior Management for Teachers and Parents*, you can break the cycle. You'll learn special techniques for managing adolescent behavior, ways to work with ADHD children, and how to implement a token reward management system. Priced at $34.95, this guide is available by calling Manisses Newsletter Book Service at (800) 382-0602 or (703) 684-4057.

ADHD

from page 1

An objective test for ADHD, such as the McLean test, could help clinicians "more accurately identify those children who, without question, have a biological disorder and would benefit from pharmacologic intervention," Teicher said.

In the McLean study, researchers used an infrared motion analysis system to record the movement patterns of 18 boys with ADHD and 11 non-ADHD control subjects as they sat before a computer and performed a repetitious attention task. The system tracked the position of four markers placed on each boy's head, back, shoulder and elbow 50 times per second with a high degree of resolution.

Test results showed that the boys with ADHD were two to three times more active than controls their own age and had larger-amplitude, whole-body movements. Researchers also were able to accurately discriminate 16 of the 18 boys with ADHD from all 11 of the controls.

"What this test measures is a youngster's capacity to sit still," Teicher said. "There are a lot of children who know they should sit still and have the capacity to sit still, but just don't. This test is able to detect the children who know they should sit still and try to sit still, but physically are unable."

A child's capacity to sit still often distinguishes a child with ADHD from a child who may have a simple behavioral or neurologic problem or learning disorder. "It surprises me how often clinicians say 'ADHD,' when the problem is really a learning disorder, particularly when there is no evidence of ADHD and no evidence that medications help learning disorders," Teicher noted.

Whereas previous tests have focused entirely on attention as an indicator for ADHD, the McLean test uses recent advances in video technology to accurately measure both attention and body movement.

"Finding and treating ADHD can make a big difference in a child's academic success," Teicher said. "Paradoxically, misdiagnosing a case of ADHD can cause great difficulty as the medications used to treat ADHD can make children with other disorders worse. So far, our results indicate that this test enables us to rapidly adjust medication to find the dose that normalizes the child's capacity to sit still and attend." ■

Subtle brain abnormalities implicated in ADHD

Subtle structural abnormalities in the brain circuit that inhibits thoughts have been confirmed in the first comprehensive brain imaging study of attention-deficit/hyperactivity disorder (ADHD). Magnetic resonance imaging (MRI) scans of 57 boys with ADHD, ages 5 to 18, also revealed that their brains were more symmetrical than those of 55 age-matched controls.

Three structures in the affected circuit on the right side of the brain — prefrontal cortex, caudate nucleus and globus pallidus — were smaller than normal in the boys with ADHD, when examined as a group. The prefrontal cortex, located in the frontal lobe, just behind the forehead, is believed to serve as the brain's command center. The caudate nucleus and globus pallidus, located near the middle of the brain, translate the commands into action.

"If the prefrontal cortex is the steering wheel, the caudate and globus are the accelerator and brakes. And it's this braking, or inhibitory, function that is likely impaired in ADHD," explained F. Xavier Castellanos, MD, who conducted the study with colleagues at the National Institute of Mental Health.

ADHD is thought to be rooted in an inability to inhibit thoughts. Finding smaller right hemisphere brain structures responsible for such executive functions strengthens support for this hypothesis.

The NIMH researchers also found that the entire right cerebral hemispheres in boys with ADHD were, on average, 5.2 percent smaller than those of controls. The right side of the brain is normally larger than the left. Hence, the ADHD children, as a group, had abnormally symmetrical brains.

"These subtle differences, discernible when comparing group data, hold promise as telltale markers for future family, genetic and treatment studies of ADHD," said Judith Rapoport, MD, chief of the NIMH child psychiatry branch. "However, because of normal genetic variation in brain structure, MRI scans cannot be used to definitively diagnose the disorder in any given individual."

The study appears in the July issue of the *Archives of General Psychiatry.*

The researchers are currently following up on a recent discovery of a link between ADHD and a gene variant known to code for a particular receptor subtype for the neurotransmitter dopamine. "We want to see the extent to which children with this gene variant also have the brain structural abnormalities revealed in this study," Castellanos said.

Child, Adolescent Depression Distinct from the Adult Version

If your child has seemed persistently sad, is uninterested in previously enjoyable activities, and seems at the same time to be doing worse in school, it may be more than "just a phase." About 5 percent of adolescents and 1 to 3 percent of prepubescent children suffer from significant depression.

Depression in children may manifest itself differently than in adults. In addition to the symptoms above, children may complain of headaches, stomach aches or persistent boredom. If you have noticed that your child's eating or sleeping patterns have changed, or that your child's school performance is deteriorating, these may be other signs of depression.

Rather than wait and hope that your child is merely passing through a phase, it's probably best to see a mental health professional. Untreated depression can cause unnecessary suffering or even suicide.

Correct diagnosis

The first step is to get a diagnosis. The same symptoms can be caused by other medical problems, and the mental health professional first needs to rule out such conditions as sleep disorders, substance abuse or the early stages of adolescent schizophrenia.

If the symptoms do indicate depression, there are varying degrees of severity and duration. Your child may suffer from an adjustment disorder with a depressed mood, from dysthymia, or from major depression.

Bipolar disorder (manic-depressive illness) is rare but possible in children and adolescents. Both major depression and bipolar disorder have significant genetic components; if there is a family history of depression or bipolar disorder, they are more likely to surface early in childhood or adolescence.

Treatments

Pharmacologic treatment of adult depression has improved dramatically in the past two decades, and antidepressant drugs have been successful for adults. Unfortunately, antidepressants seem to be less successful for depressed children and adolescents.

This may be because neural pathways are still immature, or

Continued. . .

. . . continued

because chemical balances are different during adolescence. Currently, doctors prescribe antidepressant medications on a case-by-case basis, and some youth do seem to benefit from them.

Active and focused talk therapy seems most successful with depressed children and adolescents. A therapist can address your child's distorted thinking and self-impressions, such as feelings of hopelessness, helplessness, worthlessness, or a combination of perfectionism and low self-esteem.

Because children and adolescents are so dependent on adults for caretaking, the therapist may wish to assess your child's home environment. The therapist may look for abuse, neglect, family conflict or school difficulties. Answering his or her questions honestly will help your child the most.

Severe depression in childhood or adolescence is frequently a chronic and recurrent disorder. As many as 70 percent of school aged children treated for major depression will have a recurrence of depressive symptoms within a five-year period.

However, most depressed children and adolescents respond to various combinations of psychotherapy, family therapy, pharmacologic treatment and environmental improvement. As with most psychiatric disorders, earlier diagnosis and treatment is associated with faster and more complete recovery.

Source: Gregory K. Fritz, M.D., is a professor of psychiatry at Brown University Medical School and director of child and family psychiatry at Rhode Island Hospital, Providence, RI.

The Brown University Child and Adolescent Behavior Letter

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What's New in Research

Child mortality down; suicide, homicide up

While child mortality has declined significantly since 1950 — primarily because of decreases in deaths from unintentional injuries and disease — since 1968 there has been a two- to three-fold increase in suicide and homicide among children, according to a recent statistical analysis. Male, African-American, Native American, Hawaiian and Puerto Rican children, as well as those from lower socioeconomic backgrounds, continue to be at increased risk of early death. In a similar analysis of mortality among young adults ages 15 to 24, the same researchers found no appreciable reduction in youth mortality from 1950 through 1993, especially among males. Declines in mortality from accidents have been nearly offset by increases in deaths from homicide, suicide and firearm injuries. Substantial differences in mortality divided demographic and socioeconomic groups, with the death rate for young males being two to three times that of females, and the rates for African-Americans and Native Americans being, respectively, two and four times higher than that for whites. Those in low educational and income groups were also at increased risk for premature death. Overall, adolescent mortality has declined by 13 percent since 1979. Motor vehicle deaths; substance use; and gonorrhea and syphilis have all been reduced. But these gains continue to be challenged by violence, poverty and risk-taking behaviors.

"U.S. childhood mortality, 1950 through 1993: trends and socioeconomic differentials" and "Trends and differentials in adolescent and young adult mortality in the United States, 1950 through 1993," Gopal K. Singh, PhD, et al., and "Morbidity and mortality among U.S. adolescents: an overview of data and trends," Robert Blum, MD, PhD, et al., *American Journal of Public Health*, 86(4):505-519, 560-564, 1996.

Teen victims of violence lack psychosocial care

Mental health consultation is apparently not routine for adolescent victims of violence who are hospitalized for wounds from gunshots, stabbings and physical assaults, according to a recent study, despite the association of such injuries with psychological stress. Researchers at San Francisco General Hospital compared the records of all patients under 18 who were hospitalized in 1991 after violent intentional injuries and after suicide attempts. They found that, of the adolescents who were victims of assaults, only 49 percent received comments on their hospital charts about mood, and in only 58 percent of cases was mental health consultation sought. Only 9 percent of these young people were referred to follow-up mental health care after their discharge from the hospital. The level of concern for young patients' mental health was much higher for adolescents who had attempted suicide: 93 percent of these adolescents' charts recorded comments about mood. Moreover, the treating physician sought consultation from a mental health professional for 96 percent of the patients who had attempted suicide, and 61 percent were referred for follow-up mental health care.

"Interventions among adolescents who were violently injured and those who attempted suicide," Miriam Shuchman, MD, et al., *Psychiatric Services*, 47(7):642-643.

ADHD children at higher risk for psychiatric disorders

A recent study supports previous research suggesting that children and adolescents with attention-deficit/hyperactivity disorder (ADHD) are at increased risk of comorbid conduct, mood and anxiety disorders, as well as impairments in cognitive and interpersonal functioning. A group of children with ADHD and a group of control subjects were given structured diagnostic interviews at one- and four-year follow-up assessments. Subjects were rated on their degree of behavioral, mood, and anxiety disorders, as well as on cognitive, social, school and family functioning. These disorders increased markedly from baseline to follow-up, and children with ADHD were significantly more impaired than controls in cognitive and psychosocial functioning.

"A prospective four-year follow-up study of attention-deficit hyperactivity and related disorders," Joseph Biederman, MD, et al., *Archives of General Psychiatry*, 53:437-446, 1996.

Do boot camps work?

An evaluation of three boot camps for juvenile offenders showed that the youths improved in educational performance, physical fitness and behavior. But the aftercare phase of the program was marked by high levels of dropout and recidivism. The federally funded programs in Cleveland, Denver and Mobile, AL were designed to be alternatives to institutionalization for non-violent offenders, all boys ages 13 to 18. The three-month camps emphasized discipline and work, but also required that treatment and rehabilitation be the ultimate objectives. Boot camp completion rates were high in the first year of the programs, ranging from 80 to 94 percent. But this promising figure changed when the youths went back home. Nearly half of those who graduated to the aftercare phase of the program dropped out, were arrested for new offenses, or were discharged for not complying with the programs' rules.

"Boot camps for juvenile offenders: an implementation evaluation of three demonstration programs," Blair B. Bourque, et al., *National Institute of Justice Research in Brief*, May 1996. For a full report, write to the National Criminal Justice Reference Service, PO Box 6000, Rockville, MD 20849-6000; call (800) 851-3420; or e-mail askncjrs@aspensys.com. Ask for NCJ 157316.

Keep Your Eye On

... eating patterns.

New guidelines from the Centers for Disease Control and Prevention (CDC) offer recommendations to school health programs in promoting healthy eating patterns to last a lifetime. On average, American children and adolescents eat too much fat and sodium and not enough fruits and vegetables. School-based nutrition education can prevent the development of diet-related problems such as undernutrition, iron-deficiency anemia and obesity, according to the CDC. The guidelines recommend, among other things: adopting a schoolwide policy on nutrition; making nutrition education a part of the curriculum from preschool through secondary school; and making sure the cafeteria reinforces healthy messages. An appendix lists resources for nutrition education materials.

For a copy of the guidelines, send $2.25 to the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325, or call (202) 512-1800, and ask for MMWR 1996;45(No. RR-9).

... pollution.

Recent evidence suggests that a family of common pollutants known as endocrine disrupters can lead to learning disorders and even brain damage in children. Scientists have previously implicated endocrine disrupters — which include PCBs, dioxin and related chemicals — in reproductive problems such as decreased sperm counts and increased rates of breast and testicular cancer, but new evidence suggests that these pollutants could be causing mental and behavioral problems in children whose mothers were exposed to them. Research conducted in the Great Lakes region shows that children whose mothers had eaten large amounts of PCB-contaminated fish before becoming pregnant performed less well on tests of cognitive ability than children whose mothers didn't eat fish. The exposed children also had smaller heads and weaker reflexes. Similar effects have been observed in mice and rats.

A report on the further study of endocrine disrupters is expected to be issued in March by the National Academy of Sciences.

... stressed-out parents.

Mothers' and fathers' stress is caused more by the separate pressures of their job and family roles than by any conflict that arises from the demands of having both job and home responsibilities, a new study suggests. Neala S. Schwartzberg, PhD, and Rita Scher Dytell, PhD, found that parents derive their self-esteem from accomplishments at work rather than accomplishments at home, while their emotional state of happiness or depression is obtained from the relationships they have within the family. Their study did not find any support for the idea that men's sense of well-being is defined by their work experiences while women's well-being is defined by their experiences within the family. Work stress turned out to be more important in determining the self-esteem of mothers than fathers, while family stress appeared to be more important in determining depression for fathers than mothers. The findings are consistent with previous studies indicating that working fathers seem to be more attuned to their emotional relationship with their spouses, whereas working mothers seem more attuned to the amount of assistance they get around the house. *Journal of Occupational Health Psychology*, 1(2):211-223, 1996

... exposure to smoking in utero

The more a woman smokes during pregnancy, the greater the chance that her child will have mental retardation, a new study reports. Researchers interviewed 221 mothers of mentally retarded children and 400 mothers of non-retarded children about cigarette use during their pregnancies. They found that women who smoked while pregnant were 50 percent more likely to have a mentally retarded child than were nonsmoking women. Women who smoked at least one pack of cigarettes a day during pregnancy were 85 percent more likely to have a mentally retarded child. While these are correlational, not causal, data, it appears that about 35 percent of unexplained cases of mental retardation in children of women who smoke could be related to maternal smoking during pregnancy. *Pediatrics*, 87(4):547-553, 1996.

... and in the house.

Household exposure to passive smoke for asthmatic children may constitute abuse and neglect and should be a factor in child custody cases, researchers say. Their study of the impact of passive smoking on children's health found that tobacco is associated annually with 284 to 360 deaths; 300 fire-related injuries; 354,000 to 2.2 million ear infections; and 529,000 doctor's visits for asthma. Among children under the age of 5, exposure to cigarette smoke is implicated in 260,000 to 436,000 cases of bronchitis and 115,000 to 190,000 cases of pneumonia. While more than 20 states allow smokers the right to smoke when not working, no state has enacted a law recognizing the right of children to remain free from harm as a result of the smokers' use of tobacco products, the researchers note. *Pediatrics*, 87(4):560-568, 1996

Recommended Reading

Anxiety Disorders in Children and Adolescents — *John S. March, Ed. Guilford, 1995, 448 pages, $40*

Childhood-onset anxiety syndromes forecast adult anxiety disorders. Edited, with contributions by authors Joseph Biederman, Jerome Kagan, Jane Costello, Dennis Cantwell, Keith Connors and many others, this book is regarded by some as the most comprehensive volume on anxiety disorders in young people.

Successful School Restructuring — *Fred M. Newmann and Gary G. Wehlage, Board of Regents, University of Wisconsin, 1995, 64 pages*

A progress report deserving of attention by practicing educators, administrators, policy-makers, researchers and the public, this report comprises five years of research synthesized by the Center on Organization and Restructuring of Schools at the University of Wisconsin. Education reformers have recently been calling for restructuring of schools. This progress report helps to decide whether site-based management, interdisciplinary team teaching, flexible scheduling and assessment by portfolio are working, as indexed by boosts in student achievement. The report concludes that structural reforms work when human and social resources are organized to provide particular forms of support for schools and students.

Assessment of Parenting: Psychiatric and Psychological Contributions — *Peter Reder and Clare Lucey, Eds., Routledge, New York, 1996, 291 pages, $18.95*

An in-depth guide for mental health practitioners and others doing complex child care assessments for the courts. It explains how to structure parent assessments, how to determine whether harm has been done, and how the disciplines can work better together.

Taking Charge of ADHD: The Complete, Authoritative Guide for Parents — *Russell A. Barkley, Guilford, 1995, 294 pages, $16.95*

An excellent buy for parents concerned about the possibility their child has attention-deficit/hyperactivity disorder, as well as those whose child already has the diagnosis, by one of the pioneers and reputedly finest clinicians dealing with the disorder. Barkley is director of psychology and professor of psychiatry and neurology at the University of Massachusetts Medical Center.

The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy — *Daniel N. Stern, Basic Books, New York, 1995, 229 pages, $35*

The noted author/psychiatrist describes what may be a powerful new paradigm for understanding the relationship between parent and child, "the motherhood constellation." Parents' representations of their relationship with the child, overt interactions between parent and child, the child's representations of these reciprocating behaviors, and the place of the therapist in this system are all regarded as of great importance in the dialogue of therapy.

Coming Up

New guide lists federal aid

The newly published *1996 Guide to Federal Funding for Education* details $46 billion in federal aid available for education and education-related programs. The guide describes almost 400 federal grant programs of importance to state and local education agencies, school administrators, educators, universities and community colleges, community-based organizations, students and researchers, and service providers. The topics covered include elementary and secondary education, job training, vocational education, math and science, rehabilitation, child care, and social and health services for children and adolescents. The *Guide* describes and analyzes all legislative and regulatory action of the past year, and subscribers will receive a budget update to be delivered when final funding levels are determined for federal agencies in the current fiscal year.

A subscription to the two-volume *Guide* includes program updates and a twice-monthly calendar of grant deadlines. **Cost:** $368.95, plus $14.95 for shipping and handling. **Contact:** Education Funding Research Council, 4301 North Fairfax Drive, Suite 875, Arlington, VA 22203, (800) 876-0226 or (703) 528-1000.

Child protection advocates to meet for conference

The 11th National Conference on Child Abuse and Neglect is scheduled for Sept. 16-21 in Washington, DC. The conference, sponsored by the National Center on Child Abuse and Neglect and other organizations, draws psychologists, social workers, physicians, teachers, child advocates, judges, community leaders and others who work in the field of child protection. **Contact:** Research Assessment Management, 1300 Spring St., Suite 210, Silver Spring, MD 20910, (301) 589-8242.

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Commentary

Understanding the cruelty of theft

My car window was smashed in a split second and the thieves were off with my briefcase.

Although I have previously suffered the loss through theft of possessions that were valuable to me and my family as remembrances of times past, I have never experienced such grief as I do now over the loss of personal property. I have lost 180 slides in a carousel tray with which I had just been lecturing to public school teachers at a local zoo. Also, the staff of Zooscope, a collaborative project between Roger Williams Park Zoo and Brown University, gave me a book, and I had it in my briefcase. Numerous personal papers are also gone relating to my research with children, some of it on babies who die of sudden infant death syndrome, and some on the causes of learning disabilities in youngsters.

I feel disabled myself by the theft of my documents and slides. I am not asking "Why me?" I am asking "Why anyone?" Why do these people steal?

These questions led me to ponder the profound differences between our culture and the culture of some other developed cities and countries, such as Stockholm, Sweden — where, by comparison, there is little theft and little misbehavior of all sorts.

In Sweden few children are unwanted. Moreover, any parents found physically hurting their child, even on the pretense of discipline, are instantly arrested. And again, anyone found in public with a gun or a knife is instantly arrested, as are people driving drunk: No questions asked or answered until the next morning when the judge delivers justice, for the benefit of "the people."

As a researcher in the field of child development, I am persuaded (even by some of the data that have just been stolen) that for youngsters to become contented adolescents and adults, they must grow up feeling that the world they were born into is a place that welcomed them and continues to look after their well-being. Children who are not born under this minimal blanket of security will feel cheated, and will believe that what others have should be theirs. They will have little regard for the feelings or well-being of others, and they will have a high probability of growing up assaultive toward others and with a disregard of their belongings.

To feel secure in, on and with their property and in the streets, humans require interaction with a community of other well-meaning people who themselves had the good fortune to be born into the hands of someone who has loved them and regarded them as autonomous, worthwhile, valuable and valued persons. To grow up believing oneself to be undervalued — or worse, not cared for, nurtured or loved at all — is the scourge of the current human condition.

In my research with children, I have hoped throughout my career to contribute knowledge about the nature and nurture of human development. At the same time, I have wanted to be able to say something important about what we as a society might do to improve the human condition. Children and adolescents desperately need our careful attention, but many have been having trouble catching it.

We live in an age when yet more severe cuts are occurring in programs for prenatal care, for needy and unwanted children, for teenagers trying not to become pregnant, for good programs of foster care and adoption, and so many other preventative programs. Many child development specialists, teachers and board members of child advocacy organizations will tell you what is going on: We as a society don't really care much for children and adolescents, particularly those born into disadvantage, and so they are going to do the best they can to secure for themselves what they would like to have, often at the expense of life, limb and property of others. Life has become increasingly dangerous, and this trend will escalate until we understand that there are grave problems that need *very* intensive attention. ■

P.S. After writing the above, the police called to say, "We have your briefcase." After a brief expression of relief and thanks to the officer, I asked nervously, "Are my slides there?" "Yes," he said. "We don't know if any are missing, but there's a box with a tray of slides. And lots of papers." My wife and I rushed to the station, found the sergeant who had called, and retrieved the briefcase. It was an enormously gratifying reunion. The time and energy that could have been required, and the amount of distraction from my regular work, to set things right after such a loss, would have been beyond belief. The only remaining frustration I have is that I don't even know who found the briefcase and returned it. Ironically, besides a few inconsequential things — perhaps stolen forever or dumped somewhere — the book was not in the recovered briefcase. The book's title: *Beastly Behavior*!

Lewis P. Lipsitt

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Prenatal development

Cocaine's role in drug-exposed babies' problems questioned

By Ed Susman

Exposure to cocaine in the womb has virtually no effect on early childhood development, according to two studies presented at the American Psychological Association's annual convention in August.

Crack babies are not doomed, says LeAdelle Phelps, PhD, professor of counseling and educational psychology at the State University of New York at Buffalo. Another study by researchers at Temple University lends support, suggesting that, while crack babies might have lower birth weight than other newborns, differences in long-term development were difficult to find.

Previous findings of problems in babies exposed to drugs in the womb may in fact have been caused by factors other than cocaine use.

Phelps' study compared two groups of preschoolers — 20 children who had been exposed to cocaine/polydrugs in utero and 20 children with no prenatal drug exposure — who were matched for age, ethnicity/race, gender and socioeconomic status.

The children were given a battery of psychological tests, including the Stanford-Binet Social Skills Rating System, the Vineland Adaptive Behavior Scale, the Preschool Language Scale and the Child Behavior Checklist.

"By the time these children are 2 years old, there is no evidence that there is any effect on their develop-

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Inside This Issue

The nation's governors get together to discuss ways to reduce youth violence in their home states.

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Children are having sex as early as elementary school.

See page 7

Is brief therapy too brief for pediatric psychopathology?

See page 8

Coming Soon:
The world of pretend.

This month's client handout

You can end the 'step wars' with peaceful step treaties

Parenting

Distant, critical fathers may be agents in their daughters' eating disorders

Fathers who avoid closeness yet criticize their daughters' weight and diet may create an atmosphere that leads to eating disorders, new research suggests.

A study comparing women hospitalized with anorexia or bulimia to women without eating disorders found that the level of a father's intimacy with his daughter has a more significant influence on development of eating disorders than her mother's.

"The message may be that fathers should be more accepting of their children," says Renee Goodwin, a researcher at the Northwestern University Medical Center.

Goodwin and her colleagues, Jeffrey J. Haugaard, PhD, of Cornell University, and psychologist Fran Luckom-Nurnberg, discovered that the hospitalized women reported significantly less intimacy and acceptance and more avoidance and concentration on faults from their fathers than did women who had no history of eating disorders. But overall, both groups of women reported far fewer differences in relationships with their mothers.

The researchers, who presented

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The Brown University Child and Adolescent Behavior Letter

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Fathers and daughters

from page 1

their findings in August at the American Psychological Association's annual convention in Toronto, recruited 25 single women who were inpatients on the eating-disorder unit of Gracie Square Hospital in New York City. All had a clinical diagnosis of either anorexia nervosa or bulimia nervosa and had been in the hospital for at least two weeks. They ranged in age from 13 to 33. The comparison group was composed of 26 single female college undergraduates who reported never having an eating disorder and scored below eating-disorder criteria on standard tests.

The researchers used four self-report measures: the 91-item Eating Disorders Inventory, the nine-item Attachment Scale, the 17-item Intimacy Scale and the 202-item Family Relations Inventory. In an open-ended interview, they also assessed, among several things, a woman's relationship with her father on a 1-5 scale — 1 representing a relationship of no communication, hostility and anger; 5 representing a close relationship featuring good communication.

The researchers defined acceptance as a relationship in which the parent regards the child as a full-fledged member of the family who needs a certain degree of independence. In avoidance, a parent neglects or rejects a child. In concentration, a parent disproportionately directs control of a child.

Researchers found that the eating-disordered patients reported a lower level of acceptance and attachment in their relationships with their fathers, and a higher level of concentration and avoidance. "The undergraduates reported a higher level of intimacy in their relationships with their fathers than patients did," the researchers reported.

Fathers of both groups of women spent a similar amount of time with their daughters, but the relationship was less satisfactory for the patients than for the undergraduates.

"The objective measures indicate that the father-daughter relationship is unsatisfactory, not because the father is never around — he is closely monitoring his daughter and her actions — but when he is around, he monitors her actions while he avoids her emotionally and refuses to accept her," Goodwin says. "He demands that she achieve a great deal without giving the emotional support she needs to accomplish such achievements."

Fathers of women with eating disorders were significantly more concerned with weight and dieting issues than were fathers of women without eating disorders.

"The fathering style of emotional neglect and overcontrol, combined with the fathers' preoccupation with weight and dieting, may have influenced the daughters' focus on eating and dieting," Goodwin says.

The study found little difference in mother-daughter attachment between the two groups, nor was there a significant difference in weight and dieting issues among the mothers. "These findings are consistent with a previous study that reported that both

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parents of anorexics are both too nurturing and too neglectful," the researchers say.

Interviews with the fathers themselves and direct observation of father-daughter interactions would have made the study more complete, the researchers say. They also say their study is limited by the questionable statistical reliability of the open-ended interviews with the women, although results were tallied by three independent scorers.

> **The fathering style of emotional neglect and overcontrol may have influenced the daughters' focus on eating and dieting.**
>
> *— Renee Goodwin*

"Still, the majority of statistical analyses were performed with the data from the objective measures, which have statistical reliability and were found to be consistent with the interview data," Goodwin says. In fact, the research showed a statistically significant difference between the women with eating disorders and those without on each score relating to attachment, intimacy, acceptance, concentration and avoidance. The difference between acceptance scores was greater than twofold, and that between avoidance scores, fourfold.

There were significant differences between the mother-daughter relationships as well, but there was no statistical difference for the quality of attachment.

Women with eating disorders were equally dissatisfied in their relationship with both parents, but this was not the case for the comparison group. But the key, Goodwin says, is how fathers of the patients seemed to be highly critical of the daughters' weight and diet.

"It is possible that biological, social, individual and familial factors influence the etiology of eating disorders," Goodwin says. "The finding that father-daughter relationships of the patients and non-eating-disordered undergraduates are significantly different, and that patients experience their fathers as overly watchful and monitoring, emotionally avoidant, unaccepting and very concerned about weight and dieting, suggests that the father-daughter relationship may be one of the familial factors."

A closer examination of this factor may yield important information about the psychogenesis and treatment of anorexia and bulimia, Goodwin says. ■

For a reprint of the research paper, "The father-daughter relationship as a psychogenic factor in the development of eating disorders," write to Renee D. Goodwin, BS, at Northwestern University Medical Center, 233 E. Erie St., #1008, Chicago, IL 60611.

Keep Your Eye On

... kids' smoking.

The American Academy of Pediatrics (AAP) threw its support behind the final U.S. Food and Drug Administration (FDA) plan to reduce youth tobacco use. The plan, which President Clinton unveiled Aug. 23, gives the FDA the authority to regulate tobacco products as drug-delivery devices. Amid reports of increased youth drug use, advertising restrictions and public education can help fundamentally change the way children and adolescents think about cigarettes and chewing tobacco, says Richard Heyman, MD, chairman of the AAP's committee on substance abuse. "Limiting children's daily dose of tobacco propaganda is critical," he says. "It can aid our efforts to reinforce the notion that tobacco and other drugs are not the way to gain acceptance or deal with one's problems."

... and where they see it.

The U.S. Department of Justice is launching a probe of Hollywood's images of smoking. The department's criminal division will "thoroughly review" whether the portrayal of smoking in the movies "is caused in whole or in part by payments of money or other things of value by tobacco industry representatives to the movie industry to induce them to feature tobacco products." The practice, known generally as "product placement," is illegal if the product is cigarettes because it then makes the movie into a form of advertisement, requiring a congressionally mandated health warning. The probe was instigated by a formal complaint by the anti-smoking organization Action on Smoking and Health (ASH), which cites several studies showing an escalation in the number of movies not only featuring smoking scenes, but also showing specific brands.

For more information on Action on Smoking and Health, write to ASH, 2013 H St., NW, Washington, DC, 20006, or call (202) 659-4310.

... funding for drug abuse prevention.

Election-season recriminations are flying in the wake of a Department of Health and Human Services survey showing that drug use among 12- to 17-year-olds rose from 5.3 percent of those surveyed in 1992 to 10.9 percent in 1995. GOP presidential candidate Bob Dole and several

Republican leaders in Congress blamed President Clinton, arguing that he had cut the staff of the drug czar's office and had not spoken out forcefully enough against teen drug use. The Clinton camp points the finger back at the Republican-dominated Congress for failing to fully fund drug abuse prevention and treatment programs authorized by the 1994 crime law. According to Justice Department figures, Clinton had requested $2.4 billion for the Safe and Drug-Free Schools and Communities program from 1994-97, but Congress has appropriated $1.9 billion.

... mothers in jail.

The growing number of women prisoners who have young children is raising concerns about the impact of tougher sentencing guidelines on these children. Patricia M. Wald, one of 11 judges on the U.S. Court of Appeals for the District of Columbia Circuit, sharply criticized the guidelines' presumption that family ties and obligations are ordinarily not relevant, according to an article in *The New York Times* Aug. 20. The U.S. Sentencing Commission wrote the guidelines, which took effect in 1987, as part of an effort to standardize sentencing. Although judges can make exceptions in extraordinary cases, the courts disagree on how to define "extraordinary." In an Aug. 26 letter to the editor of the *Times*, psychologist James W. Prescott called the imprisonment of mothers of young children, when probation or alternative sentencing is available, "a crime against humanity." Prescott wrote, "Substantial scientific evidence has documented the failure of maternal-infant affectional bonding as a major cause of depression, alienation, anger or rage, violence and substance abuse."

... the road.

Children with severe attention-deficit/hyperactivity disorder (ADHD) may become bad drivers later on, according to a study sponsored by the National Highway Traffic Safety Administration (NHTSA). The study found that young adults who had been diagnosed with severe ADHD as children were more likely than a comparison group to have been convicted of certain moving violations. As a group, the 113 severe ADHD young adults had more convictions for moving violations than the comparison group, which was made up of young drivers without ADHD, as well as those who had displayed moderate and situational symptoms of ADHD as children. The two groups showed statistically significant differences in violations for speeding, failure to obey signs and signals, following too closely and illegal passing. The severe ADHD group also had more convictions in almost all categories of non-moving violations, including licensing, failure to appear in court, failure to pay fines and ignoring police authority. The severe ADHD drivers had slightly higher — but not statistically significant — percentages of crashes. Among both groups, only two recorded crashes involved fatalities; both of these crashes involved severe ADHD drivers.

For a copy of the report, "Analysis of driving histories of ADHD subjects," write to the Office of Program Development and Evaluation, NHTSA, NTS-30, 400 Seventh St., SW, Washington, DC 20590, or send a fax to (202) 366-7096.

... managed care.

More than 20 million American children could be at risk in the transition to managed care, according to a new study. The study's authors, from the School of Hygiene and Public Health at Johns Hopkins University, say more than 200 chronic conditions and disabilities affect children. About one-third of children under age 18 have one or more chronic health conditions, including asthma, diabetes, sickle cell anemia, spina bifida, epilepsy and autism. The authors call on child health professionals to advocate both within and outside the public health system to ensure quality care for these vulnerable children.

For a reprint of the article, "Assuring quality of care for children with special needs in managed care organizations: roles for pediatricians," which was published in *Pediatrics*, 98(2):178-185, 1996, write to Henry T. Ireys, PhD, Department of Maternal and Child Health, 624 North Broadway, Baltimore, MD 21205.

... innovative parenting information.

It's not slick, and its readers are among the poorest families in Texas, but a recent survey indicates that the no-frills newsletter *Texas Tots* is helping to get parents to take their babies in for checkups. About a third of the 283 parents interviewed by the publisher, Partners with Children and Families, said that they took their babies in for checkups after reading the newsletter. A majority of parents also reported that they played more games with their babies, had clearer expectations about normal development and handled stress better because of the newsletter. Each issue of *Texas Tots* is devoted to a specific developmental stage, so that when a family's baby turns 5 months old, an issue describing what to expect of 5-month-olds shows up at their door. The three-year-old publication will go to 415,000 parents on Medicaid across Texas this year. About 100 hospitals and clinics around the state also distribute prenatal and newborn issues to parents. The newsletter, which costs an average of 32 cents an issue to write, print and mail, is supported by 13 state and private agencies, including the Texas Department of Health.

For more information on the publication, write to Partners with Children and Families, PO Box 4800, Austin, TX 78765.

You Can End the 'Step Wars' with Peaceful Step Treaties

Why did she do it? Since she remarried a divorced man with children, Irene has wondered why she "courted trouble." Before marriage, she naïvely thought that she should marry someone in the "same boat" — believing such a man would accept her boys as his own, and she would gladly accept his children as her own. What she didn't expect were the "step wars" — the angry children, visitation squabbles, custody fights — that accompanied the stepfamily arrangement.

The plight of stepfamilies in America is growing. Nearly half of all U.S. marriages — and most involve children — end in divorce, with 80% of the divorced spouses remarrying. Unique problems for stepfamilies surface over:

- stepparent authority;
- angry stepchildren;
- stepsibling relationships;
- extended stepfamily relationships (stepgrandparents, for example);
- legal rights of stepparents;
- etiquette questions for special family functions; and
- arrangements for wills, college education and other financial matters.

Fortunately, statistics on remarriage and stepfamily satisfaction rates show that the quality of stepfamily living is better than the popular conception. The myth of the "wicked stepmother or stepfather," for example, doesn't match most stepchildren's reports.

However, when stepfamily conflicts grow too difficult to handle at home, counseling or psychotherapy can help. When Irene found herself unable to cope with the stress, she brought her family for counseling. Family agreements were reached that transformed the step wars into successful step treaties.

- **Unfinished business**. Once in counseling, family members can talk about the feelings of anger, neglect, guilt and other emotions remaining from first marriages.
- **Visitation and jealousy**. Parents and stepparents often experience feelings of jealousy around visitation issues. Therapy talks between parents often can solve the competitive and jealous concerns and smooth the hurt feelings.
- **Discipline and the children**. Learning better ways to discipline children and avoiding overprotection by the biological parent are common stepfamily problems. Therapists may recommend establishing contracts for proper behavior, using time-outs to isolate disruptive children, or employing "huddling" before enforcing punishments.
- **Loyalty conflicts**. Having custodial parents communicate directly with noncustodial parents instead of having children carry messages back and forth reduces the loyalty dilemma.
- **The extended family.** Develop an stepfamily support system by using grandparents, stepgrandparents and other relatives and steprelatives for child care and babysitting to help allow a "honeymoon period" to occur in the new marriage. This important development provides for growth between the new spouses.

In family treatment, a stepfamily can transcend the myth of "instant love" — the unreasonable expectation of immediate love in step relationships — and instead develop truly loving feelings over time.

Many stepfamilies skilled in communication and conflict management can and do work through such difficulties on their own. Also, much of the frustration of family life in a stressful society is just as taxing for first marriages. Besides, stepfamilies offer unique advantages as well. One example is the increase in available emotional support and

Continued . . .

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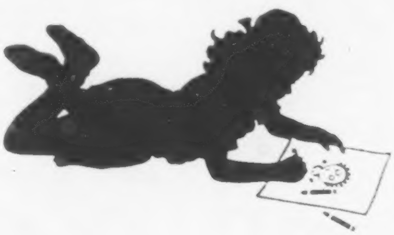
other resources from the larger, more extended family. Another is the opportunity the children have for learning how to cope with an ever changing and complicated world due to the social and emotional complexity of their own stepfamily environment.

Although stepfamilies have unique problems, educational groups, self-help groups or family counseling can assist in their formation and growth. The unusual set of stepfamily problems that often lead to step wars, can be resolved through the creation of specifically designed step treaties. Working towards such solutions requires patience, commitment and love, but will help to make a supportive, loving and safe environment for children and stepchildren.

Source: Christopher J. Pino, Ph.D. is a clinical psychologist.



The Brown University **Child and Adolescent Behavior Letter**

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Prepared by Helen Ebrahim, production coordinator.

Cocaine in utero

from page 1

ment," Phelps says. "We didn't find any social problems arising by the time the children were 5 years old." This finding contradicts previous studies, which have suggested that crack babies develop social problems later on.

All of the children in the study scored about one standard deviation below the expected average in social skills, auditory comprehension, expressive language and externalizing behavior difficulties.

"The results suggest in utero drug exposure had no independent impact on cognitive, social, language and behavioral developmental outcomes when the confounding variables were controlled," Phelps says.

In fact, in most instances, the children who were exposed to cocaine scored higher on some tests than did those who weren't exposed to illegal drugs.

The only significant group differences among nine variables studied independently and in interaction with one another were verbal reasoning and expressive language scores, Phelps says. "In both cases, it was surprising to find that the cocaine/polydrug-exposed children performed significantly better than did their non-drug-exposed counterparts," she says.

Since none of the children was attending a preschool program, this difference couldn't be attributed to child-focused interventions.

There was a significant difference between those who took care of the toddlers in each group. Twelve of the 20 cocaine-exposed children were living with caretakers other than their biological mothers, such as grandmothers or foster or adoptive parents, whereas only five of the 20 non-exposed preschoolers lived with non-biological families. This suggests that if babies of cocaine-using mothers could be placed with presumably drug-free caretakers, their early exposure to drugs need not have enduring effects.

"Clearly, the postnatal environment can either attenuate or exacerbate the risk factor of such exposure," Phelps says.

Previous findings of problems in babies exposed to drugs in the womb may in fact have been caused by factors other than cocaine use, Phelps says. Drug exposure "is often exacerbated by myriad socioeconomic and environmental factors which place children at considerable risk for developmental and psychoeducational difficulties," she says.

> **While preterm birth puts an infant at risk, the environment to which the child returns appears to be the most significant variable to impact on those risks.**
>
> *— Abigail Cohen, PhD*

But when Phelps carefully matched the two groups, developmental differences disappeared. "All of the developmental afflictions frequently linked with intrauterine drug exposure occurred as frequently or more frequently in the non-drug-exposed group as in the cocaine-exposed group."

She suggested that a media and professional "rush to judgment" that these children were devastated by their mothers' cocaine use proved not to be true. She said the real problem behind the children's slower-than-average progress had more to do with poverty than with their exposure to drugs.

Similar results were found by Abigail Cohen, PhD, and her colleagues at Temple University.

Using data collected from an urban neonatal intensive care unit, the researchers identified 483 preterm infants, 29 percent of whom had been exposed to cocaine during pregnancy.

When using criteria to identify those who had been exposed to cocaine, experts were successful only one-fourth of the time, suggesting that the data presented misleading information 75 percent of the time.

"The results indicate that outcomes previously associated specifically with cocaine exposure may be related to preterm birth alone," Cohen says.

Research on intrauterine cocaine exposure began in earnest about 10 years ago when it became apparent that there was an increase in the number of women of childbearing age who used cocaine. Drug exposure of infants was found to be as high as 18 to 20 percent in some urban hospitals.

"Exposure resulted in greater need for medical care for infants, higher frequency of low-birthweight, more preterm births and medical complications, longer hospitalizations and higher medical costs," Cohen says.

But the scant research on these babies' outcomes was often based on comparisons to full-term, healthy children. "The lay press, reporting the data, negatively labeled cocaine-exposed infants," Cohen says. "Recently, researchers have reconsidered outcomes assumed related to cocaine exposure and realized studies done to date have been inconclusive."

While research has shown an increase in premature birth associated with cocaine, the fact of prematurity has seldom been examined as it relates to outcomes specifically resulting from in utero cocaine exposure.

(Continued on page 6)

When Cohen and colleagues looked at all preterm babies, they found no significant differences for the groups on the morbidity rating scale score between those exposed to cocaine and those who were cocaine-free as fetuses.

Cohen says the study should help clear up the public misconception of outcomes for cocaine-exposed infants. "While preterm birth puts an infant at risk for negative developmental outcomes, the environment to which the child returns after birth appears to be the most significant variable to impact on those risks," she says. "Therefore, while cocaine-exposed infants are at risk for developmental problems, this can be ameliorated by positive enriching environments after birth. Exposure does not have to result in negative long-term outcomes for this group." ■

"Risk factors in early child development: Is prenatal cocaine/polydrug exposure a key variable?" LeAdelle Phelps, PhD, Department of Counseling and Education Psychology, State University of New York at Buffalo, 409 Christopher Baldy Hall, Buffalo, NY 14260-3154.

"The crack baby legacy: Can the myth be undone?" Abigail Cohen, PhD, 8110 Heacock Lane, Wyncote, PA 19095.

Watch coming issues for differing views on cocaine's role.

Violence

Governors explore strategies for reducing violence in schools

Calling violence in the nation's schools intolerable, governors on the National Governors' Association's human resources committee highlighted innovative strategies to combat the upsurge in juvenile crime and violence in schools.

"I don't believe there's a simple solution to eliminating violence and disruption in our classrooms. All of us, however, are attempting to address this difficult issue in each of our states," said Delaware Gov. Tom Carper, who chaired the committee session at NGA's annual meeting last summer in Fajardo, Puerto Rico.

According to Carper, components of successful state programs for preventing youth violence include parental involvement, strong leadership, an early start, long-term commitment, quality staff development, interagency partnerships and community linkages.

Colorado Gov. Roy Romer noted that his state has taken a two-pronged approach to combating youth violence by cracking down on youth offenders and developing early intervention strategies. As part of this preventive agenda, Romer has spearheaded a program called Bright Beginnings, which has the ambitious goal of visiting every family with a newborn within the child's first three weeks of life to offer support and advice.

"I think one of the most fundamental problems of juvenile behavior is parenting," Romer said. "Government can't substitute (for parents), nor should it try, but government should really try to find a way to encourage, community by community, a non-governmental response."

Some epidemiologists are predicting that by 2010, the 15- to 19-year-old population of juvenile offenders will increase by 30 percent. "The issue is what we can do as governors to make sure that what some of these experts predict does not occur," said Ohio Gov. George V. Voinovich, who is encouraging courts to use community-based services to better meet the needs of juvenile offenders in a program called RECLAIM.

Joining the governors in their discussions on school violence were Wade F. Horn of the National Fatherhood Initiative and Peter Blauvert of the National Alliance for Safe Schools. Horn said that to stop violence in the classroom, schools need to provide structure, clear rules and immediate consequences.

Blauvert challenged governors to give back control to the individual schools. "Every school has got to identify for itself what are the issues that are causing fear and anxiety on the part of kids and then deal with it," he said.

The young face of violence

- ✔ Children under age 18 now account for about 20 percent of violent crime in the United States.
- ✔ About 135,000 guns are brought into schools each day.
- ✔ One-fourth of all suspensions from schools nationally were for violent incidents committed by elementary school students.

The NGA committee members approved several new policies and amendments to existing policies on:

- **Elementary and secondary education.** Provides an overview of the leadership role that governors play in implementing comprehensive school reform efforts and lays out principles for federal involvement in elementary and secondary education.
- **Head Start.** Supports the creation of a well-integrated, cost-effective system of full-day and full-year child care and education across the states. Lists 12

recommendations for improving collaboration between Head Start programs and states.

- **Crime.** Suggests that state and local governments develop a comprehensive program to address violent crime, including sexual violence, domestic violence, child abuse, hate crimes, youth violence, violence against elders and illegal access to handguns. Reaffirms the governors' support for the underlying principles of the Juvenile Justice and Delinquency Prevention Act and calls for Congress to re-examine the purpose and impact of the act on states.
- **Substance abuse and drug trafficking.** Outlines basic principles and privacy standards, as well as standards to promote coordination and information-sharing among criminal justice systems.
- **Missing and exploited children.** Endorses legislative, educational and law enforcement support programs for missing children.
- **Teen pregnancy.** Offers recommendations for state- and community-based approaches to teen pregnancy prevention.
- **Children and family services.** Outlines principles for reforming programs that serve children and their families and lists areas of strong gubernatorial commitment to ensure coordination and effectiveness of the multiple programs currently serving children.
- **Employment security.** Calls on Congress and the president to work with states to reform the current employment security system. ■

What's New in Research

Kids are having sex as early as fifth grade

Parents who try to convince their teenagers to hold off on having sex may be way too late. A study of fifth- and eighth-graders in low-income elementary and junior high schools found that 46 percent of the fifth-graders and 55 percent of the eighth-graders had already had sexual intercourse. In fact, sex was more common than smoking or drinking in both grades. Among the fifth-graders, 6 percent said they smoked half a pack of cigarettes or more a day, while 23 percent said they used to smoke but no longer do. One percent said they drank one to three days a week, and an additional 3 percent said they drank on weekends. Among the eighth-graders, 6 percent said they smoked half a pack or more a day and 14 percent said they used to smoke. One percent said they drank one to three days a week, and 13 percent said they drank on weekends. The 59 fifth-graders and 169 eighth-graders were evenly split by gender, but not by race. In the fifth grade, 66 percent of the children were white and 34 percent were black, Hispanic or "other." Among the eighth-graders, 39 percent were white and 61 percent were black, Hispanic or "other." The researchers attributed the high rates of sexual intercourse in their study in part to the students' lower socioeconomic status; the lack of stimulating programs and opportunities during non-school hours; and personal values that make it permissible to engage in sex.

"Pathways of influence on fifth and eighth graders' reports about having had sexual intercourse," Cornelia P. Porter, PhD, RN, et al., *Journal of Research in Nursing and Health*, 19:193-204, 1996. For a reprint, write to Dr. Porter, University of Michigan, School of Nursing, 400 North Ingalls Building, Ann Arbor, MI 48109.

Not all teen dieters are bingers

Adolescent dieting doesn't necessarily lead to bingeing, says a new study that suggests that bingeing behavior is, in some cases, not connected with dieting. This finding contradicts previous research suggesting that dieting has a significant effect on bingeing. Researchers studied the eating habits of 421 adolescents from different socioeconomic backgrounds in New York City and surrounding suburbs. The researchers asked each adolescent to report his or her eating habits over a two-day period and recorded a 24-hour recall of the foods they ate to evaluate the quality of their diets. They also measured the adolescents' body mass index. The study found that not all dieters were bingers: Some binged and others were strict dieters. Dieters who did binge may have done so because they restrained their eating to a point that sometimes when they began to eat they had difficulty stopping. But nearly half of the dieters were also bingers, a cause for concern because a combination of excessive dieting and bingeing could put an adolescent at risk for eating disorders. Body weight also seems to have an effect on bingeing behavior: Thinner dieters were more likely to lose control and binge, whereas heavier dieters tended to stick to their diets.

"Restrained eating among adolescents: dieters are not always bingers and bingers are not always dieters," Sunyna S. Williams, PhD, et al., *Health Psychology*, 15(3):176-184, 1996. For a reprint, write to Dr. Williams, Department of Psychology, State University of New York College at Buffalo, Buffalo, NY 14222.

Commentary

Fast fixes and brief therapies

Most of us in the fields of psychology and child development have grown up with a negative attitude toward quick psychotherapies. Our supposition, spawned and embedded in the psychoanalytic presumption that everything is deep and difficult to understand, has been that interventions that work fast must be superficial, and may be ineffective over the long term.

Yet, all of us know individuals who have been seriously, fundamentally and permanently affected by swift, and often fortuitous, circumstances in their lives. Many adolescents have poignant experiences that turn their lives around — a chance conversation with a school counselor that hits the right chord, a minister who says the critical thing for the moment, the sudden death of a parent or sibling, or a near miss while driving, swimming, fighting or drinking.

People often change their behavior and even their attitudes rather quickly. Recovering alcoholics can tell you what day, and sometimes the hour and minute, their behavior changed drastically from drunken to sober. If drinking alcohol is the problem for such individuals, and a fast fix works in changing the behavior, who can knock it?

> **Even Sigmund Freud, the originating champion of the "talking cure," was willing to try his helping hand in just a session or two ... One has to suppose that Freud thought a minimal consultation might in some instances confer an advantage on the patient's anxiety, fear or depression.**

Even Sigmund Freud, the originating champion of the "talking cure," which often involves hundreds of hours spread over years, was willing to try his helping hand in just a session or two. Historians have revealed numerous instances of brief professional contact that Freud allowed, especially with celebrities who happened through Vienna and wanted to have the special advice of the master — on the run, as it were. One has to suppose that Freud thought a minimal consultation might in some instances confer an advantage on the patient's anxiety, fear or depression.

Most students of child development theory, and of the earliest practical applications of behavioral psychology, know of the pioneering clinical intervention devised by Mary Cover Jones in the 1920s. Confronted with children who had debilitating phobias, Dr. Jones capitalized on known behavioral principles of learning, generalizations, extinction and trust. She successfully suppressed a severe phobic reaction of a child who was deathly afraid of thunder and lightning. Dr. Jones anticipated when a storm was on the horizon but of which the child was hardly yet aware. Taking the child by the hand and walking with him "into the storm," this trusted person and her closeness in the presence of the feared events essentially "deconditioned" the child's fear.

The new popularity of brief therapies has received a boost from health maintenance organizations, which are increasingly reluctant to subsidize long-term psychotherapy, especially for patients who have adjustment problems that do not rise to the level of severe mental illness.

To upgrade my knowledge concerning brief therapies for children, I recently attended three mornings of lectures by psychologists Lawrence Shapiro and David Greenbaum, and came away believing that expert therapists can accomplish a great deal of beneficial behavioral and emotional change, briefly, in children who are in need of psychological help. While neither lecturer dismissed the probable advantages of long-term therapy for some individuals, each was convincing in his promotion of the value of short-term therapies for many children. I was impressed with the *variety* of brief therapies now under development, some of them already well-documented. Impressive, too, was the report that about 85 percent of the people who ever have sought psychotherapy went for one session only. When asked why they did not return for more, they said, essentially, "That did the trick for me."

Of great importance in the process of developing, documenting and promoting brief therapies will be the research enterprise. It will be the task of the scientists — some of them the clinicians themselves — to evaluate the differential efficacies of various therapies with children presenting with different problems. There is a great scientific mission ahead, just as there has been in other arenas of biomedical and behavioral science. It involves the scientific verification of the claims of clinical presumptions. What doesn't work will have to be discarded. What works will be accepted. What remains ambiguous and controversial must be subjected to more study. ■

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Infancy

Babies' cries give insight into much, including SIDS

By Barry Lester, PhD

The analysis of infants' crying may have diagnostic utility as a screen for those at risk for sudden infant death syndrome (SIDS), and for the early detection of infants who may be at risk for poor developmental outcome due to such biological insults as prematurity and prenatal drug exposure.

From a theoretical perspective, infant crying is a biosocial phenomenon. As a biological signal, the cry provides information about the biological integrity of the infant, such as when there has been some insult to the nervous system. As a social signal, crying affects parenting and is one of the ways in which infant characteristics contribute to the developing infant-parent relationship.

Communication is a dyadic event, and much of the early parent-child relationship is negotiated around crying.

Research on the acoustical analysis of infant crying began early this century with the invention of the sound spectrograph, which provided, literally, a picture of the cry from which some quantification was possible. With this technology, it became possible to describe distinct patterns of normal crying, such as the basic, or hunger, cry and the pain cry. The sound spectrograph also made it possible to describe cry patterns in certain medical conditions in which clinical observation suggested that the cry was abnormal. For example, *cri du chat* is a trisomy condition named for the abnormal-sounding, cat-like cry of affected babies. The advent of high-speed com-

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Mothers who were abused as children may be emotionally withdrawn or hostile to babies.
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Youth-bashing for votes?
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Coming Soon:
Have child-rearing practices kept pace with an increasingly complex world?

This month's client handout
Top 10 signs of a good kindergarten classroom

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Gender

Girls rise to challenge of adolescence and the world around them

In negotiating the rocky terrain of middle school, young adolescent girls are discovering who they are at the same time they're learning what society expects them to be. That they do it so skillfully is one of the most important findings of a new report on girls in middle school.

Commissioned by the American Association of University Women Educational Foundation, the report, *Girls in the Middle: Working to Succeed in School*, represents two years of qualitative research with girls at six middle schools across the country. Besides a close-up look of girls in their school context, the report makes suggestions for educational reforms that foster an equitable climate for student achievement.

"There's a lot out there about what girls' weaknesses are; we think it's really important to look at girls' strengths," says Sukey Blanc, a research associate for Research for Action, the Philadelphia-based educational research organization that did the legwork for the report. "We need to look at girls as strong people who are working hard to make sense of their lives, and who have many kinds of suc-

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The Brown University **Child and Adolescent Behavior Letter**

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Girls

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cesses. That's one of the things that we're looking at: that their successes be defined in more than one way."

Between November 1994 and March 1995, researchers made two visits to each of the six schools selected for their variety of geographic locations and demographics. They sat in on dozens of classes and other formal and informal activities, interviewed hundreds of girls in focus groups and individually, and solicited perspectives from boys, school staff, parents and community members. At each school, they shadowed five to eight girls through their school days, interviewing them and their friends, teachers and parents.

"As our researchers talked with young adolescent girls across the country, we heard girls' accounts of the pressures to be 'nice' and quiet, to get along with everyone, to avoid conflict or even notice," the 114-page report says. "But we also heard girls describe themselves with pride as having a 'loud voice,' being tall, being willing to stand up for their beliefs."

These girls — identified as "successful" by adults and peers in academics, creativity, leadership or athletics — make strategic choices about how they approach their school lives, the researchers found. And their success in school depends partly on how well their approaches work in specific settings.

The report describes three strategies:

- **Speaking out:** Some girls, usually those with a strong sense of self, insist on being heard. And while these girls can become highly visible and effective school leaders, some of them get labeled as troublemakers.
- **"Doing school":** Some girls do what they're asked and speak in turn, if at all. This demeanor meets traditional expectations, and it may present a workable solution for girls whose home and school personas overlap. For others, their apparent compliance may mask an uneasy fit between their own identity and the school culture. These girls, who are, in the researchers' terminology, "playing schoolgirl," may be keeping a lot of uncertainty and pain to themselves.
- **Crossing borders:** Girls who are able to cross borders between different cultures may achieve success in and out of school. These girls tend to be recognized by adults and peers alike as "successful" and "knowing everybody." Given the right environment, they emerge as school leaders who understand, communicate and even facilitate others' interactions across distant worlds, such as school and community or adults and adolescents. But these talents can just as easily go unrecognized.

While a girl's main strategy may seem to represent her identity, the researchers call for a careful distinction between the two. She may be trying out different approaches to find the one that best fits her sense of self and, just as important, her place in the world around her.

This synergy between a girl and her school can either support

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including higher subscales on language and cognition and higher scores on a separate language test. This study suggests that mothers who are better able to read their infants' signals — in this case, crying — can provide the kind of parenting that facilitates cognitive and language outcome. ■

Barry Lester is director of the Infant Development Center, which includes an Infant Crying and Behavior Clinic, at Women & Infants Hospital in Providence, RI. He is also professor of psychiatry and professor of pediatrics at the Brown University School of Medicine. Dr. Lester co-edited the book Infant Crying *(Plenum) on crying as a biobehavioral phenomenon.*

Keep Your Eye On

... overweight kids.

Why are nearly one-fourth of American children overweight? Researchers at the U.S. Department of Agriculture's Children's Nutrition Research Center are conducting a two-year study they hope will help answer this question. "The number of overweight children in this country has risen dramatically over the past several years," says Margarita Treuth, MD, an assistant professor of pediatrics at Baylor College of Medicine. "This study will establish a baseline, a first step in an effort to find out what causes children to gain excessive weight." The study, which is funded by a grant from the National Institutes of Health, will focus on how and why children gain weight. "Children who are overweight face an increased risk of serious health problems such as high blood pressure and high blood cholesterol," she says. "These conditions boost a child's risk of future heart disease."

... juvenile justice.

The U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) has proposed relaxing some requirements of the Juvenile Justice and Delinquency Prevention Act (JJDPA). Authorization for the JJDPA was set to expire on Sept. 30. Congress currently is considering reauthorizing the act. To receive formula grant funds under the JJDPA, states currently must comply with four mandates, set out in Part B of Title II, that require: the deinstitutionalization of status offenders (DSO); sight and sound separation of juveniles from adults; removal of juvenile offenders from jails; and addressing the disproportionate minority representation in the state juvenile system (see the May and June 1996 issues). The proposals would loosen several adult and juvenile separation restrictions and, in some instances, provide states with more flexibility in housing and detaining offenders. The proposals come at a time when legislation that seeks to loosen or do away with the mandates is wending its way through Congress. The bill that would have the most dramatic effects on the JJDPA mandates is the Violent Youth Predator Act of 1996 (HR 3565). The bill would eliminate existing mandates tied to funds currently authorized by the JJDPA and allow states to apply for block grants and incentive grants.

... HIV control.

Public health programs promoting safe sex practices have contributed to a significant decline in the rate of new HIV infections among young men in Thailand, according to a study funded by the National Institute of Allergy and Infectious Diseases (NIAID). As reported in the Aug. 1 issue of the New England Journal of Medicine, researchers led by Kenrad E. Nelson, MD, of the Johns Hopkins University School of Hygiene and Public Health, studied groups of men drafted into the Royal Thai Army in 1991, 1993 and 1995. Since Thai men are selected for military service by lottery, these groups comprise a representative cross-section of young men in this country. Each new recruit was tested for HIV and interviewed extensively about his medical and sexual history. HIV prevalence ranged from 10.4 percent to 12.5 percent among men recruited in 1991 and 1993, but dropped to 6.7 percent among 1995 recruits. The decline in HIV prevalence coincided with reductions in several types of behavior associated with a high risk for HIV infection. For example, the percentage of men who reported having sex with female sex workers — 50 percent of whom are infected with HIV in Thailand — during the year before their conscription decreased from 57 percent to 24 percent between 1991 and 1995. Condom use in these situations increased from 61 percent in 1991 to more than 92 percent in 1995. "These findings show that behavioral interventions can be effective tools in the control of HIV transmission," says NIAID director Anthony S. Fauci, MD. Fauci adds that the findings underscore the importance of NIAID's HIV vaccine efficacy trials network (HIVNET), which provided funding for the study. NIAID established the HIVNET in 1993 to lay the groundwork for conducting large-scale clinical trials of HIV prevention strategies.

Violence

Bullies see more of TV violence, less of adults

When researchers from the Center for Adolescent Studies at Indiana University asked kids what causes fights, the two answers that kept coming up were gossip and bullying. But most of the research on bullies focused on their victims.

So the researchers asked 558 sixth-, seventh- and eighth-graders at a Midwestern middle school about their own bullying behavior. Based on their responses to a questionnaire, the researchers divided the students into three groups: those who engaged in little or no bullying behavior (228), those who reported a moderate level of bullying (243) and those who reported excessive amounts of bullying behaviors (87).

Those who reported the highest bullying behavior were also most likely to report significantly greater levels of forceful parental discipline, viewing of TV violence, misconduct at home and in the community, and fighting. They also spent less time with adults, had fewer adult role models and fewer positive peer influences. About a third of the toughest bullies lived in a stepfamily household, and 36 percent lived in a single-parent household.

The findings do not necessarily reflect a cause-effect relationship, says Kris Bosworth, PhD, who is on sabbatical from Indiana University while she is working on a youth violence prevention project at the Centers for Disease Control and Prevention. "We don't have any longitudinal data. What these studies do is raise questions."

The bullies also had a higher level of exposure to gang activity and easier access to guns than those who engaged in less or no bullying behavior. "People who work as school counselors have been saying for years that bullying was a problem," Bosworth says. "But now kids have different ways of dealing with conflicts. Part of that is easier access to firearms, but it's also a lack of social skills for coping with conflict."

If children and adolescents who are at risk of becoming bullies are identified, they could be targeted for appropriate programs, she says. "Seeing how much more fighting the bullies get into — whether they start it or are just responding — we need to focus on this group if we want to keep schools peaceful." ■

Recommended Reading

VIEWING VIOLENCE: HOW MEDIA AFFECTS YOUR CHILD'S AND ADOLESCENT'S DEVELOPMENT — *Madeline Levine, Doubleday, New York, 256 pages, $22.95*

The basic premise of this book is that media violence is the root cause of evil behavior of children and adolescents. But you don't have to buy that premise to appreciate the book. It is well-documented with child development literature to convince the reader that at least one of the major contributors to childhood and adolescent aggression and hostile behavior is "the media." The author, a psychologist, makes her case through a conscientious review of the laboratory and ethological literature on attachment, aggression and cognitive development. She argues that the acquisition of morality by young people is largely a matter of learning how to solve problems, how to settle battles, how to gain retribution and, in general, how to disinhibit, through watching others, including fantasy figures, take care of their dilemmas, hurts and conflicts by instigating or counteracting with expressions of aggression. The author provides age-graded advice on how to soften the blows that she is convinced the media endorse, promote and instigate.

HORACE'S HOPE: WHAT WORKS FOR THE AMERICAN HIGH SCHOOL — *Theodore R. Sizer, Houghton Mifflin, Boston, 198 pages, $22.95*

In the third book of his Horace triology, Ted Sizer revisits American classrooms to reassess the past decade of educational reform. What he discovers there is the sobering reality that change is hard. Raising educational standards is demanding and unsettling, and communities have little incentive to do so. But he also found much that is encouraging: better attendance, higher morale, fewer disciplinary problems and more graduates. And while the empirical data are admittedly scanty, the trends are in the right direction. Sizer, professor emeritus at Brown University, offers his observations on the 10th anniversary of the Coalition of Essential Schools, a group of schools across the country united by a common vision of intellectual purpose. The idea is that students should master a limited number of essential skills and areas of knowledge, instead of being overloaded with a "comprehensive," but necessarily superficial, curriculum. "We do know now that the status quo of shopping-mall high schools and lecture-drill-and-test systems demonstrably do not work for too many pupils," Sizer writes in *Horace's Hope*. This is his eloquent entreaty that change is less risky than habits that sap young minds.

Top 10 signs of a good kindergarten classroom

Kindergarten is a time for children to expand their love of learning, their general knowledge, their ability to get along with others and their interest in reaching out to the world. While kindergarten marks an important transition from preschool to the primary grades, it is important that children still get to be children—getting kindergarteners ready for elementary school does not mean substituting academics for play time, forcing children to master first grade "skills," or relying on standardized tests to assess children's success.

Kindergarten "curriculum" actually includes such events as snack time, recess and individual and group activities in addition to those activities we think of as traditionally educational. Developmentally appropriate kindergarten classrooms encourage the growth of children's self-esteem, their cultural identities, their independence and their individual strengths.

Kindergarten children will continue to develop control of their own behavior through the guidance and support of warm, caring adults. At this stage, children are already eager to learn and possess an innate curiosity. Teachers with a strong background in early childhood education and child development can best provide for children what they need to grow physically, emotionally and intellectually.

Here are 10 signs of a good kindergarten classroom:

1 Children are playing and working with materials or other children. They are not aimlessly wandering or forced to sit quietly for long periods of time.

2 Children have access to various activities throughout the day, such as block building; pretend play; picture books; paints and other art materials; and table toys such as Legos, pegboards and puzzles. Children are not doing the same things at the same time.

3 Teachers work with individual children, small groups and the whole group at different times during the day. They do not spend time only with the entire group.

4 The classroom is decorated with children's original artwork, their own writing with invented spelling and dictated stories.

5 Children learn numbers and the alphabet in the context of their everyday experiences. Exploring the natural world of plants and animals, taking attendance and serving snacks are all meaningful activities to children.

6 Children work on projects and have long periods of time (at least one hour) to play and explore. Filling out worksheets should not be their primary activity.

7 Children have an opportunity to play outside every day that weather permits. This play is never sacrificed for more instructional time.

8 Teachers read books to children throughout the day, not just at group story time.

9 Curriculum is adapted for those who are ahead as well as those who need additional help. Because children differ in experiences and background, they do not learn the same things at the same time in the same way.

10 Children and their parents look forward to school. Parents feel safe sending their child to kindergarten. Children are happy; they are not crying or regularly sick.

Individual kindergarten classrooms will vary, and curriculum will vary according to the interests and backgrounds of the children. But all developmentally appropriate kindergarten classrooms will have one thing in common: The focus will be on the development of the child as a whole. ■

Source: The National Association for the Education of Young Children.

Additional Resources:

Good teaching practices for older preschoolers and kindergarteners. 1990. Washington, DC: NAEYC #522. 50¢ each/100 for $10. Spanish edition, *Prácticas de enseñanza apropriados para niños mayores en pre-escolar y kinder*, #523.

Peck, J., G. McCraig & M.E. Sapp, *Kindergarten policies: What is best for children?* Washington, DC: NAEYC #141/$6.

Phonics and whole language learning: A balanced approach to beginning reading

Children cannot learn to read without an understanding of phonics. All children must know their ABCs and the sounds that letters make in order to communicate verbally. The question in early childhood programs is not whether to teach "phonics" or "whole language learning," but how to teach phonics in context—rather than in isolation—so that children make connections between letters, sounds and meaning.

Phonics should not be taught as a separate "subject" with emphasis on drills and rote memorization. The key is a balanced approach and attention to each child's individual needs. Many children's understanding of phonics will arise from their interest, knowledge and ideas. Others will benefit from more formal instruction. There are many opportunities to teach the sound a letter makes when children have reason to know. For example, the first letter a child learns typically is the first letter of her name.

Some teachers worry that encouraging children to learn through experience and invent their own spellings will not provide them with adequate language skills. But literacy is not so much a skill as a complex activity that involves reading, writing and oral language. Ideally, children should develop literacy through real-life settings as they read together with parents or other caring adults. Children begin to make connections between printed words and their representations in the world.

Adults should keep in mind that children may learn to read at different paces during kindergarten and first grade. This is true for all children, including those with special needs and those from linguistically and culturally diverse backgrounds. If parents and teachers work together and demonstrate mutual respect, children's learning will be reinforced at home and in the classroom.

How parents can help

Infants:

- Talk, read and sing to infants—they learn from everything they see and hear even in the first stages of life.
- Take your baby to the park, zoo and the store with you. Bring his attention to objects, signs and people.
- Always make books a part of your baby's toy selection, even if she likes handling books more than being read to. As your child grows, point out pictures of objects and offer their names. Eventually, your child will be able to name the pictures, too.
- Encourage associations between symbols and their meaning—as they get closer to toddlerhood, children may begin to recognize familiar signs for products and logos for cereal or fast-food restaurants.

Toddlers:

- Help toddlers make the transition from baby talk to adult language by repeating their words and expressions correctly without reprimanding them.
- Let toddlers "read" their favorite picture books to themselves while you remain close by to comment. Or, pause before a familiar word as you read to your toddler, and let her fill in the missing word. This works especially well with rhymes or repeated refrains.
- Provide magnetic and block letters to introduce a toddler to the spelling of his name.
- Before you take your toddler on a new type of outing, read about the events you are about to witness. Talk with your child about the experience, and follow up with further reading to reinforce learning.

Preschoolers:

- Add new books to your child's collection, but keep reading old favorites. Your preschooler may know them by heart now—this represents an important step in learning about reading.
- Continue to take children shopping with you, and let them help identify products with coupons. Let preschool children join in as you follow a recipe.
- Take books on long trips with you to encourage reading as entertainment.

School-age children:

- Continue to read to your child, even if she has learned to read already. Take turns reading pages of your favorite books.
- Encourage story writing by listening to the stories children tell.
- Play word games like Scrabble or Boggle with children and introduce them to crossword puzzles. ■

Source: National Association for the Education of Young Children.

The Brown University
Child and Adolescent Behavior Letter

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or shortchange her development, the researchers say. "The girls' strategies vary very much from context to context, depending on the kid and what makes sense in a particular context," Blanc says. "One of the important things about the idea of strategies is that it's making sense from minute to minute of what is going on around them, and trying to do what they need to do for themselves. It's not fixed, even in the course of a day, how a particular individual will interact with her environment."

Which strategy a girl chooses may depend in part on her socioeconomic and ethnic background, the report says, with middle-class and white girls more likely to present as "quiet" and "nice," and working-class girls of color likelier to risk confrontation. But class and race alone do not always predict a girl's approach.

"More critical is the match between a girl's own race/ethnicity and class and the dominant culture of her school, which might make a particular strategy feel more available to some girls than to others," the report says. "For example, a Latina in a school setting where both adults and peers were also predominantly Latino might employ a different strategic approach from a Latina in a predominantly white setting."

Whatever her way of finding her footing in the world, says the report, "nothing is more important to a girl's developing sense of self than a mentor." In interviews and focus groups, girls consistently credited certain teachers, principals, counselors and other adults — one girl named an elevator operator — as critical to their success. The report recommends scheduling time for mentoring work and offering girls opportunities for connecting with adults who understand them and can advocate on their behalf.

As the researchers got ready to leave the schools they had been studying, they discovered that their very presence had begun what they hope will be an ongoing discussion of gender equity. "That might be something that practitioners in schools can do more of: Ask girls what their lives are like, because adults often don't know," Blanc says. At one rural Southwestern school, the focus group started by the researchers continued as a girls' writing group after the researchers left.

The report urges schools to make gender equity a top priority. "We think that gender issues are always there in the classroom, and they're pressing, especially in middle schools," Blanc says. "Teachers and schools are missing a learning opportunity." ■

Girls in the Middle: Working to Succeed in School *is the last of three reports in the American Association of University Women Educational Foundation's research series on what's working for girls in school. For ordering information, contact the AAUW Sales Office, Dept. 363, PO Box 251, Annapolis Junction, MD 20701-0251, or call (800) 225-9998, ext. 363.*

An educational equity inventory

Use this list as a starting point to assess your school's work on gender equity. Taking inventory is a first step in a cycle of assessment and action.

Does your school have ...

- ✓ policies that make gender issues a priority?
- ✓ supports for girls of all races, languages, negotiating strategies and physical abilities?
- ✓ adults with whom girls can talk about issues such as sexuality, birth control and family and peer pressures?
- ✓ support in the school and the district for adults who mentor girls?
- ✓ equitable athletic programs?
- ✓ a sexual harassment policy?
- ✓ data that show student achievement by gender?
- ✓ professional development to help teachers make their classrooms more equitable?
- ✓ curricula and teaching approaches that encourage girls and boys to try out a range of roles in the process of identity development?
- ✓ adults and programs offering leadership opportunities to girls of diverse cultures who use a range of negotiating strategies?
- ✓ girls, parents and school staff involved in assessing the school experience for girls and in shaping reform?
- ✓ forums for dialogue across the various constituencies of the school community?

Source: American Association of University Women Educational Foundation.

Crying

from page 1

puter technology has dramatically improved the science of cry analysis with enhanced quantitative methods.

Clinicians have long been aware that infants with a variety of medical problems have identifiable cries; these problems include neonatal asphyxia, brain damage from various etiologies, hypoglycemia, hydrocephalus, encephalitis, meningitis, hypothyroidism, Down's syndrome, various genetic defects and oropharyngeal abnormalities. If cry abnormalities can be detected in known medical conditions, it may be possible to determine specific cry characteristics in conditions such as SIDS.

Cries of SIDS victims

In a prospective study of 21,880 infants, we recorded cries during newborns' first week of life. Twelve infants subsequently died of SIDS. Two cry characteristics were remarkable in the SIDS victims that reflect tension in the upper airway and neural control of the vocal folds. Newborns with these two cry features had a relative risk of 32, meaning that they were 32 times more likely to die of SIDS than were infants without these characteristics.

Cry analysis may also be used in the identification of infants who may have suffered central nervous system insult but whose current and future neurobehavioral status is less certain. Preterm infants are the largest group of infants at risk for poor developmental outcome. Several studies have shown early differences in acoustical cry characteristics between full-term and preterm infants, and our research has shown that cry characteristics predict long-term developmental outcome in preterm infants.

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In a two-site longitudinal study, we developed a prediction equation to classify infants with high or low cognitive scores at 30 months. This equation was then applied to a second independent sample and replicated the prediction equation.

In another series of studies, differences in cry acoustic characteristics have been related to prenatal exposure to lead and to drugs such as opiates, cocaine and marijuana.

Crying as a dyadic event

Crying is the infant's earliest form of communication, and most parents can readily distinguish their infant's hunger cry from his or her pain cry. Communication, however, is a dyadic event, and much of the early parent-child relationship is negotiated around crying. Some infants are better "communicators" than others. The acoustical features that characterize their cries are well-defined, resulting in some parents reporting that their infants are easy to read. But other parents say that they can't tell what their infant needs or wants. The parent's contribution is to interpret the cry, and to translate the interpretation into an appropriate response, and parents also vary in these abilities.

Research has documented how adults, parents as well as non-parents, react to infant cries using rating scales and physiological measures. In rating scale studies, adults listen to cries and rate cries along dimensions of how the cry sounds (loudness, pitch) and how the listener feels (angry, sad). In one study, teenage mothers misperceived their infant's cry: They rated cries that were higher-pitched as less aversive-sounding, whereas older mothers rated higher-pitched cries as more aversive.

Physiological studies use heart rate and skin potential responses as a measure of reactivity to infant cries. Physiological responses have been related to infant temperament and in relationship to child abuse.

Colic is a good example of how biological and social aspects of the cry combine and become problematic. Studies show that infants with colic not only cry excessively, but that the sound of the cry becomes qualitatively different, and that the mothers of these infants report more parenting stress. In colic we see how a biologically driven cry condition can cause a perturbation in the parent-child relationship that, if not repaired, could result in longer-term consequences for the child's emotional development.

The question of how characteristics of the infant and characteristics of the parent combine to determine the child's development has also been studied using infant crying. In a longitudinal study of mostly preterm infants, we used the "goodness of fit" model to define groups of matches and mismatches between the measured acoustical characteristics of one-month-old infants' cry and how their mothers perceived the cries. A match occurred when a mother rated an acoustically defined high-pitched cry as high-pitched or a low-pitched cry as low-pitched. A mismatch occurred when the mother rated a high-pitched cry as lower-pitched or vice versa. The 120 infants in this study were divided into these four match and mismatch groups.

At 18 months of age, infants in the two matched groups showed higher mental development scores,

What's New in Research

Shy kids may be at risk for anxiety disorders

Behavioral inhibition in young children is an early temperamental risk factor of the later development of prepubertal anxiety disorders, according to a review of the past 10 years of research on anxiety disorders in children and adolescents. Research evidence shows that children who are unusually shy or fearful and withdraw from unfamiliar situations are more likely to have anxiety disorders, such as avoidant disorder, separation anxiety disorder and agoraphobia, later on. The literature review also found that vulnerability to panic disorder is related to pubertal changes — panic disorder is uncommon before puberty — providing a tantalizing clue to the biological basis of the disorder. In addition to adding to the understanding of the etiology of anxiety, recent research has offered the promise of treatment success. The American Academy of Child and Adolescent Psychiatry, which released a set of practice parameters for the assessment and treatment of anxiety disorders in 1993, recommends a multifaceted but tailored approach to treatment. Specific cognitive-behavioral interventions and the introduction of the selective serotonin reuptake inhibitors have shown promise in the treatment of anxiety disorders in children.

"Anxiety disorders in children and adolescents: a review of the past 10 years," Gail A. Bernstein, MD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(9):1110-1119, 1995. For reprints, write to Dr. Bernstein, Division of Child and Adolescent Psychiatry, Box 95, University of Minnesota Medical School, 420 Delaware St. SE, Minneapolis, MN 55455.

Bedtime resistance may be more than rebelliousness

While setting a consistent bedtime may be helpful for many children who resist going to bed, children who take a longer time falling asleep and have a history of troubled sleep may experience even more distress if parents try to strictly enforce bedtimes, according to a study of children's sleep habits. The most common problem reported by the parents of 987 children ages 5 to 12 was bedtime resistance: 27 percent had marked bedtime resistance at least three days a week. Other common problems were delays in falling asleep after going to bed (11.3 percent), difficulty staying asleep (6.5 percent), difficulty waking up in the morning (17 percent) and complaints of fatigue (17 percent). While the researchers note that conventional wisdom holds that bedtime struggles among school-age children "result mainly from deficiencies in limit-setting practices," their data suggest that, for a significant subgroup of bedtime-resistant children, there may be more going on than rebelliousness. These children differ from those who simply refuse to go to bed by more anxiety-related features, such as fearfulness, night waking, need for parents' proximity, complaints of fatigue and early histories of disrupted sleep.

"Sleep problems in elementary school children," Joseph C. Blader, PhD, et al., presented at the American Psychological Association's annual meeting, Aug. 9, 1996. For reprints, write to Dr. Blader, Long Island Jewish Medical Center, Schneider Children's Hospital, Room SCH 416, New Hyde Park, NY 11040.

Mothers abused as children may relate poorly to infants

Women who have been exposed to childhood trauma are at elevated risk for hostile or emotionally withdrawn behavior and poor attachment with their own infants, according to the findings of a recent study. Mothers with a history of physical abuse tended to be more hostile toward their infants, while mothers with a history of sexual abuse tended to be more emotionally and physically withdrawn from their infants. The research was based on observations of videotaped interactions between 45 low-income mothers and infants at home and in the laboratory. The women, who were part of an ongoing longitudinal study, had a high rate of childhood trauma: Almost half (47 percent) reported sexual or physical abuse experiences before the age of 18. But the study found that attachment is a robust process, even among mothers exposed to violence and abuse. A full 42 percent of them managed to achieve secure attachment relationships with their infants. The behaviors of infants who showed insecure attachment relationships varied according to their mothers' histories. Insecure infants of mothers exposed to trauma displayed predominantly disorganized strategies, whereas insecure infants of mothers who had benign childhoods or who were neglected only displayed predominantly avoidant strategies.

"The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment," Karlen Lyons-Ruth and Deborah Block, *Infant Mental Health Journal*, 17(3):257-275, 1996. For reprints, write to Dr. Lyons-Ruth, Department of Psychiatry, Cambridge Hospital, 1493 Cambridge St., Cambridge, MA 02139.

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Commentary

Youth-bashing for votes

By Bill Howard

Sound bite by sound bite, President Clinton and Republican contender Bob Dole are demonizing young people to sway voters in November's presidential election — reinforcing negative attitudes toward youth.

"Unless something is done soon, some of today's newborns will become tomorrow's 'super predators' — merciless criminals capable of committing the most vicious acts for the most trivial of reasons: a pair of sneakers or a football jersey," Dole told a radio audience July 6, bashing our newest generation while still in their cradles.

Scapegoating teens

Clinton's demonization of youth is a little subtler. In last year's State of the Union address he called teen pregnancy and out-of-wedlock births "the nation's most serious social problem," but did not mention that research shows many girls are impregnated as victims of rape and sexual abuse by older males.

> "When I and my diapered colleagues were coming up through the ranks ... they called us children and that drove a lot of policy decisions."

Dole's charge that teen drug use has "skyrocketed," a new federal Health and Human Services study shows, is on target and has put Clinton on the defensive. But Michael Males, author of *The Scapegoat Generation: America's War on Adolescents*, notes that in 1993, there were only 98 teen deaths from illegal drug use, compared to 8,445 adult deaths — a death rate of 4.7 per million for teens versus 44.7 per million for adults, or 10 times worse. When adjusted for poverty, he says, the rate at which juveniles commit violent crimes is the same as the adult rate. Such comparative data for youth and adult outcomes get lost in the political sound bites that smear all kids.

Clinton, in this year's address, vowed to "take on [youth] gangs the way we took on the mob," putting youth in a class with the Mafia. Little came of this vow – a $1 million Justice Department experiment that equipped some police with laptop computers and sample graphics to help them identify, by their graffiti, out-of-town gangs moving into new areas. No provision was made for follow-up after identification.

Atty. Gen. Janet Reno has rolled out proposed legislation to allow federal prosecutors to try serious juvenile offenders as young as 13 in adult court, a step copied by Dole but affecting primarily the few Native American youth living on federal reservations.

Dole's prediction of a new-age surge in teen "predators" has been upstaged by new FBI data showing violent juvenile crime rates to be dropping sharply, an indication that youth work tactics now in place are taking effect. Most youth work experts agree that progress in controlling juvenile crime would have been further along by now if Congress hadn't scrapped the billions for prevention authorized in the 1994 Crime Bill.

Where are the children?

Yet neither candidate has spent much time championing greater stress on prevention. They've been content to allow the Youth Development Community Block Grant aimed at stimulating after-school programs for kids to sit in legislative limbo. It could die this year.

And Clinton's decision to sign the Republican Congress' welfare reform bill enacted in July has sent child and youth advocates up the wall. They angrily disagree with Clinton's claim that the bill is "a real step forward" for the world's richest nation, which allows 25 percent of its children to languish in poverty.

Vincent Schiraldi, a 37-year-old baby boomer who runs the Center on Juvenile and Criminal Justice in Bethesda, MD, feels the stamping of a "super-predator" label on kids is an abysmal sign for the future of American society.

"When I and my diapered colleagues were coming up through the ranks they had a different word for us: they called us children and that drove a lot of policy decisions," he said. "They built universities, funded Head Start programs and did a lot of things to make our lives better.

"Now, they're planning for future generations by building prisons."

Clearly, an issue for the coming presidential debates. But will anyone frame the question? ■

Bill Howard is editor of Youth Today, *a bimonthly publication of the American Youth Work Center, 1200 17th St., N.W., 4th Floor, Washington, DC 20036-3006.*

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Cognitive Development

Knowing isn't saying: Early receptive language abilities

By James L. Morgan, PhD

Perhaps the most consistent cognitive development research theme over the past two decades has been that of *early competence*. Innovative methodologies and sophisticated task analyses have permitted investigators to show children capable of sundry intellectual feats at ever-decreasing ages.

One area heretofore notable for a general lack of demonstrations of early competence is language acquisition. In this article, I describe recent research suggesting that children may gain grammatical competence at significantly earlier ages than has generally been thought to be possible. This research indicates that children's perceptual analyses of speech (or, *mutatis mutandis*, sign) play an important role in fostering early linguistic competence.

> ***This behavior is similar to that of adults forced to pay for transmitting each word, and therefore, very young children's speech has often been characterized as telegraphic.***

It might seem odd to raise the notion of early *in*competence in connection with language. After all, virtually every account of language acquisition celebrates the marvelous rapidity with which children learn language. On the other hand, evidence that children lack early mastery is plain for every ear to hear: Very young children rarely utter long or complex sentences, and the sentences they do utter are conspicuously missing elements.

These missing elements are not random. Instead,

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Inside This Issue

Children and adolescents with dyslexia feel a little better about themselves as they get older, according to a series of four studies of dyslexia across the life span.

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The rate of suicide attempts by adolescents in crisis is the same among white, middle-class teens in Oklahoma as in New York City and Los Angeles.

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Parents transmit their problem-solving strategies to their children, which in turn influence the children's social behavior.

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This month's client handout

Cornucopia Kids: Those Who Want Everything

Clinical Practice

EMDR: Controversial treatment may hold promise for traumatized children

By Melissa DeMeo, Associate Editor

Five-year-old Anna, who had been in two car accidents, would not let her mother out of her sight. Not only was she afraid to ride in the family car, she was terrified that a tornado would destroy their house. Even asleep, she could not escape the terror of the accidents, which haunted her in nightmares.

She came to the psychologist's office clinging to her mother. After three sessions, she was no longer fearful, the nightmares went away and she would venture on her own down grocery store aisles. "It's like she can be a child again," her mother says.

Impossible? Anna's psychologist, Robert H. Tinker, PhD, PC, would have thought so six years ago when he first heard about eye movement desensitization and reprocessing (EMDR), a controversial treatment that practitioners claim resolves traumatic memories in a few sessions. Seemingly miraculous cases, such as Anna's, have made even skeptics reconsider, but the limited research on the efficacy of EMDR has been fraught with small sample sizes and other meth-

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Language

from page 1

young children tend to preserve elements that carry the bulk of the meaning and to omit elements that signal grammatical niceties. This behavior is similar to that of adults forced to pay for transmitting each word, and therefore, very young children's speech has often been characterized as *telegraphic*. In light of this evidence, the predominating view in the field has been that children do not acquire *grammatical morphology* (see sidebar, page 3) and associated aspects of grammar until well into the third year.

A case for early grammatical competence

Recent evidence from a variety of sources suggests to the contrary that infants have acquired at least some knowledge of grammatical morphology midway through the second year. I briefly note four lines of evidence here:

- that there are perceptual bases for identifying grammatical morphemes in infant-directed speech;
- that infants begin to recognize grammatical morphemes around 13 months;
- that infants begin to recognize syntactic patterns involving grammatical morphemes by about 15 months;
- that infants' failure to produce grammatical morphemes may reflect phonological difficulties rather than deficiencies in grammatical competence.

First, Rushen Shi and I analyzed maternal speech to 12-month-olds in three typologically distinct languages — English, Mandarin and Turkish. As classes, grammatical morphemes in each of these three languages have multiple distinctive phonological, phonetic and acoustic properties.

These properties vary somewhat from language to language, and no single property accurately picks out all and only grammatical morphemes. However, in each language, these properties are highly correlated, and constellations of these properties are sufficient (as modeling with untutored neural networks showed) to pick out grammatical morphemes with very high accuracy.

Thus, information is available to infants to allow them to identify grammatical morphemes before knowing anything about their meanings or syntactic functions.

Second, adapting methods used in studies of infant speech perception, research headed by Peter Jusczyk of Johns Hopkins, as well as our work at Brown University, shows that infants begin to recognize familiar words (e.g., *cup, shoe*) in fluent speech by about 7.5 months. Early on, infants sometimes falsely recognize phonologically similar foils (e.g., *cut, sue*). By 11–12 months, such false alarms are very rare.

However, as ongoing work shows, certain false alarms reappear around 13 months. Having been familiarized to *cat*, for example, 13-month-olds false alarm to *cats*, although not to *cast*. That is, by 13 months, infants appear to recognize inflected forms as legal variants of stems. Infants are beginning to orga-

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nize their mental lexicons efficiently to take advantage of the grammatical morphology of their language.

Third, research led by Anne Fernald of Stanford University using preferential listening techniques has investigated infants' ability to detect deviations from grammatical word orders.

By 12 months, infants prefer to listen to sentences with normal, rather than grossly scrambled, word order, even though both types of sentences are spoken with typical intonation. By 15 months, infants prefer sentences with normal word order over those with local disturbances in word order involving misplacement of grammatical morphemes. These results hold only for the language that the infant is learning. Hence the observed preferences are not attributable to perceptual properties of the stimuli, such as minor variations in intonation, but instead are based on nascent knowledge of language-specific syntactic patterns involving grammatical morphemes.

Fourth, even though infants may have receptive knowledge of grammatical morphemes in the second year, they do not begin to produce them reliably until the third year. Katherine Demuth of Brown University has analyzed children's early productions across a variety of languages and has found that the elements they omit and the set of grammatical morphemes are not coextensive. Rather, omitted elements predictably occupy particular positions in the phonological structures of utterances. Thus, the "telegraphic" character of early speech appears to reflect difficulties in phonological production rather than deficiencies in syntactic competence.

This is not to claim that children have acquired perfect receptive competence before age 2; clearly, they have not. Knowledge of word meanings is limited and much of language processing is poorly automatized in very young children, hindering effective coordination of the multiple skills required for expert language comprehension. Nevertheless, even at this tender age, abetted by perceptual analyses of input speech, children have made substantial progress in discovering the structure of their language.

Morphology: What does it mean?

Defined literally, *morphology* means "the science of form." Within psycholinguistics, *morphology* denotes the study of word forms. Many English words are derived from combinations of meaningful or functional components, like *acquisitions*:

acquire	*stem morpheme* carrying core meaning
-tion	*derivational morpheme* changing word from verb to noun other examples are *-ness*, *-ly*, and *-ize*
-s	*inflectional morpheme* signaling grammatical properties (e.g., relevant to agreement)—other examples are *-ing* and *-ed*

Derivational and inflectional morphemes, along with grammatical words such as articles (*the*), prepositions (*of*) and auxiliary verbs (*is*), make up the *grammatical morphemes* of a language. Grammatical morphemes carry important information about sentence structure, allowing speakers to express meanings flexibly, compactly and unambiguously.

Grammatical morphemes can be distinguished from stem morphemes on a variety of dimensions. Whereas languages rarely add new grammatical morphemes, they readily add new stems. Many grammatical morphemes occur with very high frequency and tend to be short, unstressed and phonologically simple.

Languages known as *pidgins* are notably deficient in grammatical morphology. Pidgins, invented by adults lacking any common language who need to communicate, are notorious for clumsiness and ambiguity. Interestingly, when children acquire pidgins, they reanalyze certain stems as grammatical morphemes. The resulting *creole* languages have all the flexibility and expressive power of natural languages such as English.

Implications for practitioners

If perceptual analyses of speech play a critical role in fostering early language learning, then knowing whether infants have fully functional auditory sensory abilities assumes particular importance. Some states have begun screening neonatal hearing, using non-invasive techniques such as oto-acoustic emission testing.

Making such screening universal is an important goal to be advocated. Existing tests of early language functioning focus primarily on production. Introduction of straightforward assessments of receptive capabilities will permit earlier identification of (and hence earlier interventions with) infants at risk for delayed or deficient language development. ■

James L. Morgan, PhD, is associate professor of cognitive and linguistic sciences, Brown University, Providence, RI.

EMDR

from page 1

odological shortcomings. And although several studies involving children are in the works, to date none has been published.

Desensitize and install

During the treatment, while the patient thinks about the traumatic memory and the negative beliefs, emotions and bodily sensations associated with it, he or she visually tracks a wand, or the therapist's fingers, moving rapidly back and forth in front of the patient's face. This "desensitization" phase is followed by the "installation" phase, during which the patient is asked to think of positive thoughts and repeat the eye movements. After each set, patients rate their level of distress on the Subjective Units of Disturbance Scale (SUDS), which ranges from 0 (neutral) to 10 (the highest level of disturbance imaginable). With successful treatment, the SUDS score quickly drops to normal range, and the memory becomes less intrusive and painful.

Too weird to believe

"I think everybody is skeptical at first. You say, 'What? And it does *what?*'" says Tinker, who treats both children and adults in his Colorado Springs practice. "But a colleague of mine who had 20-some years of experience had taken the training and talked to me about how utterly amazed he was at the results. When you hear something like that, you're intrigued, but you're still going in with the stance, 'Well, they're not going to fool *me*.'"

The typical session consists of several sets of eye movements conducted over the course of an hour to an hour and a half. Between sets, the patient describes his or her memory of the traumatic event, which, according to some case reports, changes dramatically over the course of the session. EMDR therapy with children is much shorter, says Tinker, who intersperses five- or 10-minute sessions with play therapy or talk therapy.

Patty-cake works, too

Children over the age of 8 can usually follow an abbreviated version of the adult protocol, but younger children (under age 5) aren't often able to track with their eyes. Other forms of left-right stimulation, such as physical taps or auditory clicks, work just as well, Tinker says. In fact, a game of patty-cake is a tailor-made EMDR technique.

Part of the mystique of EMDR is its unknown mechanism of action. Some evidence suggests that traumatic memories are stored differently from mundane memories.

Young children are often unable to come up with the positive and negative cognitions that are central to EMDR. Their memories can be elicited by having them draw a picture. And instead of rating their distress numerically, as adults do, children may be asked to describe how they feel by pointing to their place on a spectrum between a happy face and a sad face.

Even a child with developmental delays can be successfully treated with EMDR, says Tinker, who describes the case of a child born with fetal alcohol syndrome. The boy, who was 2 years and 9 months old when Tinker saw him, had the language skills of a 12- to 18-month-old child. He had been born with a cleft palate, which was corrected surgically, but the little boy regained consciousness during the operation. Since then, he had suffered from night terrors so severe that his screaming kept his grandparents up all night and could be heard by neighbors across the street.

"I was able to modify the procedure enough so that after two sessions of EMDR, he completely stopped having nightmares," Tinker says. "He became much less hyperactive; he began sleeping through the night; he no longer had night terrors; and he didn't have to be hospitalized."

The young patient was then treated with speech and physical therapy, and he tolerated subsequent hospitalizations over the next year without suffering from night terrors.

Children don't abreact

Regardless of the logistical modifications, children differ from adults in their emotional response to the treatment. "Adults abreact: They have this emotional outpouring that's related to the original event," Tinker explains. "It's unusual for a child to abreact like an adult does. You might get a tear trickling down the cheek, but frequently the child looks fairly placid. It looks like nothing has happened, and then the child comes back the next week, and you find out that the nightmares are gone, or the bed-wetting has stopped, or the fearfulness and apprehensiveness during the day is no longer there. So you have to coach the parents to be good observers."

But how does it work?

Part of the mystique of EMDR is its unknown mechanism of action. Some evidence suggests that traumatic memories are stored differently from mundane memories. The neural stimulation of eye movements may somehow facili-

Cornucopia Kids: Those Who Want Everything

Children who demand only the best, who have a need for constant stimulation, who do not follow through on projects and who have a great need to be accepted by others are exhibiting the behavioral characteristics of what Bruce A. Baldwin has dubbed "Cornucopia Kids."

It is not unusual for achieving parents to have these "Cornucopia Kids." When the children begin to show the inevitable signs of immaturity and unrealistic expectations, these parents often seek help from family therapists in attempting to break the unhealthy patterns.

Baldwin, a nationally known psychologist who deals with promoting quality of life for achievers, says the "mythical horn of plenty always represented as full to overflowing" is an apt representation of the kind of good life many middle class families are living. The problem is that often, children raised in this cozy suburban habitat leave unprepared for the real world and unable to meet adult responsibilities.

These families, though not wealthy, easily can afford all the comforts and conveniences advertised. They own all the latest electronic "toys" and diversions. This happy picture fronts a host of ills, however. "Children are not developing healthy work habits," says Baldwin. "Without realizing it, well-meaning parents are helping their children to become Cornucopia Kids."

The good life is their right

Because of their experiences at home, these children grow up believing that the good life will be there whether or not they work for it. They are not taught the direct relationship between effort and reward. Baldwin says the result of this parental behavior "is that children do not mature emotionally," and that they do not learn the values and skills necessary for success in life.

To avoid creating Cornucopia Kids, parents should attend to certain social and family concerns. First, these families are victims of a "split ethic." Baldwin notes that the parents are achievers; otherwise they would not have made it to middle class comfort. But by giving their children everything, they inadvertently raise them to be underachievers.

Secondly, the world they have created for their children is "unreal." These children grow up in a plush world, one that is probably far removed from what they can afford on their own. Therefore, children experience "culture shock" upon leaving the nest.

Finally, there is an increasing need for "character strength" in parents. They have far more material goods than their own parents ever had, and there are more fun things to buy now than ever. Parents should ask themselves whether they are strong enough not to give their children too much.

Damaging messages

Baldwin cautions that parents who give in too often inadvertently communicate a destructive subconscious message to their children that is constantly reinforced over the years: "I am in control. I can get whatever I want from my parents. I do not have to listen to anybody. Good things will come to me if I just demand them or make a scene."

"This message is internalized as a way of relating to the world and to other people and allows the Cornucopia Kid to remain immature," says Baldwin. "The child also feels an inappropriate sense of power, which is then employed to control the parent."

How can you avoid this? How do you go about training a child who has been given everything and already may be on the way to becoming a Cornucopia Kid? The answer, Baldwin says, is to give both more and less, to give fewer "things," and more time to teaching values directly that will permit children to succeed in adult life.

Baldwin says that parents can prevent or deal with Cornucopia Kids by:

- giving children regular work responsibilities. This helps to create a sense of responsibility, but also represents a personal contribution to the well-being of the entire family.
- refraining from giving children so many "freebies." Getting too much for too little

diminishes motivation and creativity. Success requires wanting something badly enough to work for it.

- giving children sensitivity training. Don't overlook rude behavior. Demanding respectful and caring behavior toward others helps sensitize children to the feelings of others and builds strong interpersonal skills.
- instilling the importance of completion as a value in children. This builds the capacity for depth of involvement and provides the perseverance necessary to complete what is started, in spite of setbacks and problems.
- teaching children to deal adaptively with failure. To fail after putting forth great effort and yet still be given parental support helps to take the ego out of failure and turns setbacks into learning experiences.
- making sure children are held personally accountable for their actions. Internal limit-setting and self-discipline are learned only when a child faces the consequences of actions with no excuses and no parental "fixing."
- creating money-management skills in children. Children should be taught to save a portion of their earnings and also the skill of comparison shopping.
- becoming involved with children in cooperative efforts. Parents can help their children to learn healthy work values by having them join in home projects, provided parents display patience and support.

Effective parenting inhibitors, or How to create a Cornucopia Kid

Giving

... to avoid confrontation or rejection.

... "things" as a substitute for time.

... as a response to marital differences.

... excessively by a non-custodial parent.

... to compensate for childhood deprivation.

... to satisfy status perceptions.

... to compensate for puritanical parents.

... is easier than denying.

... as a result of manipulation by children.

... to the baby of the family.

Simply stated, Cornucopia Kids suffer from their parents' success. It is the duty of a responsible parent to instill integrity and to create character. "If you do not accept this challenge," says Baldwin, "you may rear a child, or several of them, unable to make it in the real world and still clinging to home, indefinitely and disappointingly."

Dr. Baldwin is author of *Beyond the Cornucopia Kids: How to Raise Healthy Achieving Children!*, available from Direction Dynamics, 309 Honeycutt Drive, Wilmington, NC 28412.

The Brown University Child and Adolescent Behavior Letter

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tate the processing, or learning, of memories that have been stuck for years, says Francine Shapiro, PhD, who developed EMDR.

"The whole theory of EMDR is that whatever symptoms you're having are based on earlier life experiences," explains Shapiro, who describes treatment with children in her book *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (Guilford, 1995) and in an upcoming book for a lay audience. "The perceptions that were there at the time of the event are locked in the nervous system."

Shapiro stresses that, whatever population a therapist is working with, proper training is crucial. The process triggers intense emotions, and a couple of case reports have told horror stories of untrained therapists practicing EMDR with disastrous results, including dissociation and suicide attempts.

Works after trauma

EMDR is appropriate for discrete, single-event traumas, such as a car accident, as well as for multiple or continuous traumas, such as sexual abuse — as long as the actual crisis is over, says Tinker, who has trained clinicians in the technique in the wake of the civil war in Rwanda and Hurricane Iniki in Hawaii (see story, this page). "If a divorce has happened and is over with and the child is not being traumatized by angry, fighting parents, then EMDR will help in a short period of time," he says. "However, if the parental conflict is going on currently and you apply EMDR, it's not nearly as effective. You may get partial results, but you have to integrate it with overall family treatment and parental treatment and so on."

The effects are lasting, Tinker says. The first patient he treated with EMDR, a woman with a childhood history of physical, emotional and sexual abuse, is still stable five years later. "You have this internal framework of what kind of results to expect over what period of time, and this just violated all my internal standards," he says. "If I didn't see these changes now on a daily basis in my practice, I would still be a skeptic." ■

For more information on eye movement desensitization and reprocessing, write to the EMDR Institute, PO Box 51010, Pacific Grove, CA 93950, or call (408) 372-3900.

Hawaiian schools offer EMDR to students traumatized by hurricane

Four years after a hurricane that devastated the islands, some Hawaiian schoolchildren are still having trouble putting the trauma behind them. They have nightmares, and are terrified when the wind picks up. Students in the Kauai school district received counseling and support immediately after Hurricane Iniki struck on Sept. 11, 1992, and most of them continue to do well. But a survey of teachers and students last year revealed that a handful are silently suffering.

"We found that teachers' view of which children were distressed was not the same group of children who reported their own hurricane distress," says Joanne Nakashima, MEd, district educational specialist. "It seems that the children the teachers pick out for referral are acting out behaviorally, and the children who reported stress from the hurricane are not the usual suspects."

Some of the children hadn't even told their parents how they were feeling. "When we asked why, they said, 'They have too much to worry about. We cannot bother them,'" Nakashima says. "The strains of the family are so great and so heavy that the children feel they need to help protect the family."

For the 35 or 40 kindergartners through 12th-graders — out of 11,000 in the entire district — who scored high on measures of hurricane-related distress, "We really needed to do something more than just the regular counseling program."

At the suggestion of a trauma specialist, they decided to try eye movement desensitization and reprocessing (EMDR) treatment. "I was convinced that it was worth trying," Nakashima says. "We had tried other, conventional things that did not work."

School psychologists learned how to do EMDR in a two-day training program, and they conducted four or fewer sessions with each student.

The district has just finished collecting data from the students who received EMDR, but Nakashima says the numbers look good. Claude Chemtob, PhD, a trauma expert hired as a consultant to the school district in the wake of the hurricane, will report on the outcomes at the annual conference of the International Society of Traumatic Stress Studies in San Francisco this month.

EMDR was transformative for at least one 10-year-old, whose father was on duty as a police officer the day of the storm. "Afterwards, she had constant concerns about him," Nakashima says. "After the therapy, she had no fear anymore. That's the kind of testimony that came from the children."

Recommended Reading

Hyperactivity Disorders of Childhood — *Seija Sandberg, Ed., Cambridge University Press, 517 pages, $95*

As part of a monograph series co-edited by Donald Cohen of Yale, this intensive compilation covers the history of professional attention to children's hyperactivity disorders; epidemiological approaches; clinical aspects; developmental perspectives; sex differences; biological and cross-cultural considerations; other disorders of conduct; treatment; and association with reading disability and schooling. The contributing writers treat the development of attachment in depth, detail behavioral observation and report longitudinal outcome studies into adulthood.

Child-Centered Family Therapy — *Lucille L. Andreozzi, Wiley, 374 pages, $45*

Intended to improve the skills of therapists in addressing patients with short-term therapies for problems that once may have been thought to require long-term treatment, the volume is said by the author and publisher to be "a revolutionary short-term treatment model that has yielded nothing less than astonishing results ..."

Outcome Assessment in Residential Treatment — *Steven I. Pfeiffer, Ed., Haworth, 99 pages, $29.95*

Residential treatment centers are asked increasingly to document their effectiveness, making it incumbent upon mental health care providers to show the efficacy and cost-effectiveness of their services. This is a practitioner's guide to conducting treatment outcome research projects.

Keep Your Eye On

... child abuse

Child abuse and neglect doubled in the United States between 1986 and 1993, according to a new survey from the U.S. Department of Health and Human Services. And while the number of total child maltreatment incidents investigated by state agencies remained constant during the period, the percentage of cases investigated declined dramatically, the study shows. The report estimates that the number of abused and neglected children grew from 1.4 million in 1986, when the last National Incidence Study of Child Abuse and Neglect was conducted, to more than 2.8 million in 1993. During the same period, the number of children who were seriously injured quadrupled from about 143,000 to nearly 570,000.

... test scores.

The two-thirds of a million high school girls who entered the National Merit Scholarship competition by taking the Preliminary Scholastic Aptitude Test (PSAT) last month faced a stacked deck, according to the National Center for Fair and Open Testing (FairTest). FairTest, a non-profit group that has been critical of what it calls a gender bias in the PSAT, says that 39.5 percent of last year's 15,000 National Merit semifinalists — selected on the basis of their test scores — were girls, while 55 percent were boys (the gender of the rest could not be determined from their names). Fifty-six percent of those entering the National Merit competition are girls. "Test scores do not measure merit," says Pamela Zappardino, FairTest's executive director. "Even the test-makers admit that girls earn higher grades than boys in both high school and college when matched for identical courses. As their own research shows, the test underpredicts female performance, particularly in math."

... the SIDS rate.

For the first time since 1980, sudden infant death syndrome (SIDS) declined in 1994 from the second to the third leading cause of infant mortality, according to figures released last month by the Centers for Disease Control and Prevention (CDC). Preliminary mortality data for 1995 indicate that the SIDS rate declined 18.3 percent from 1994, representing the largest annual percentage decline since 1983. The annual rates of SIDS declined more than three times faster during the years 1990-1994 than during 1983-1989 — a trend that may reflect changes in the prevalence of known risk factors and/or changes in the diagnosis of SIDS, the CDC says. Many of the risk factors for SIDS identified during the 1980s — low birthweight, young maternal age and poor socioeconomic status — are not easily remediable, but a strong association between the prone sleeping position and SIDS had been established by 1990. The national "Back to Sleep" campaign in 1994 began promoting the non-prone sleeping position, as well as other modifiable risk factors. Racial and ethnic differences in SIDS — the rate for black infants was more than twice that of white infants during 1990-1994 — probably reflect variations in risk factors for SIDS, including socioeconomic and demographic factors, certain medical conditions (such as prematurity) and the quality of and access to health care, the CDC says. Based on preliminary data, the black-to-white ratio in 1995 was higher than during any other year since 1983, indicating that the racial gap in SIDS may be growing.

Dyslexic children grow into a sense of self-worth

Children and adolescents with dyslexia don't feel very good about themselves, but they may feel a little better as they get older, according to a series of four studies of dyslexia across the life span. In three different samples, including a clinic-referred population and a group of twins, dyslexic children and adolescents reported lower global self-worth and lower perceived competence in school, and more symptoms of depression and attention-deficit/hyperactivity disorder (ADHD) than did peers without dyslexia. The fourth study, an assessment of adult dyslexic men, found that the adults perceived themselves as less competent intellectually, reported more generalized psychological distress and showed less upward socioeconomic mobility than did their non-dyslexic peers. Nevertheless, and in contrast to the children and adolescents, the adults were comparable to their peers on measures of self-worth and depressive symptomatology. One idea is that people with dyslexia find their niche in adult life, finding jobs that suit their strengths and weaknesses and developing a strong social support network. This theory is bolstered by the finding that adults' self-worth was much more strongly related to their perceived competence in domains they considered important than to their perceived competence in unimportant domains — a pattern that is not matched in the child and adolescent groups.

"Psychosocial correlates of dyslexia across the life span," Elizabeth A. Boetsch, et al., *Development and Psychopathology*, 8(3):539-562, 1996. For reprints, write to Bruce F. Pennington, PhD, University of Denver, Department of Psychology, 2155 S. Race, Denver, CO 80208.

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Teens everywhere share risk factors for suicide

The rate of suicide attempts by adolescents in crisis is the same among white, middle-class teens in Oklahoma as it is among urban minority teens in New York City and Los Angeles, a recent study reports. And so are the risk factors: depression, substance abuse and conduct problems. More than 20 percent of the 1,616 adolescents seeking crisis services at three Tulsa agencies had attempted suicide at least once, most of them within the previous three years and almost one-quarter of them within a month of seeking services. Those who attempted suicide were more than twice as likely to be depressed as those who had not. Suicide attempters were also significantly more likely to report suicidal ideation (64.2 percent) and suicidal behavior in their families (50.5 percent). More of them used alcohol and drugs frequently, ran away, belonged to a gang and destroyed property. All of these results are consistent with data drawn from urban minority youth populations, with the single exception of method: The Oklahoma teens were more likely to cut their wrists, while most adolescents who attempt suicide ingest drugs. The researchers say their findings call for routine suicide risk assessment during intake at shelters and outpatient crisis clinics.

"Suicidal behavior among middle-class adolescents who seek crisis services," Mary Jane Rotheram-Borus, et al., *Journal of Clinical Psychology*, 52(2):137-143, 1996. For reprints, write to Dr. Rotheram-Borus, Division of Social Psychiatry, Neuropsychiatric Institute, University of California-Los Angeles, 10920 Wilshire Blvd., Suite 1103, Los Angeles CA 90024.

Fathers' problem-solving influences sons' aggression

Fathers of aggressive boys are more likely to punish them or deny or divert parenting responsibility, according to a new study. The study suggests that parents transmit their problem-solving strategies to their children, which in turn influence the children's social behavior. The mothers and fathers of 27 aggressive and 28 non-aggressive third-graders were asked how they would handle six hypothetical situations in which their sons were pressured by peers into illegal or immoral behavior, such as participating in a housebreaking. Only fathers' problem-solving strategies were related to the aggressiveness of the boys. In families with non-aggressive boys, the fathers took an active role in solving their sons' problems, while the mothers were more passive. But fathers of aggressive boys took no responsibility, and their mothers adopted a supervisory role by solving the problem themselves or punishing the child. Fathers of non-aggressive boys focused more on improving their sons' problem-solving skills by discussing with and helping them than did fathers of aggressive boys. The fathers of aggressive boys didn't find any solution to the problems.

"Parents' social problem-solving strategies in families with aggressive and non-aggressive boys," Laura Pakaslahti, et al., *Aggressive Behavior*, 22(5):345-356, 1996. For reprints, write to Dr. Pakaslahti, Department of Psychology, University of Helsinki, PO Box 4 FIN-00014, Finland.

Commentary

Child-rearing grows more complex as society changes

by Sheldon H. White, PhD

As I write, a proposed Amendment 17 to the Colorado State Constitution would declare the right of parents *"to direct and control the upbringing, education, values and discipline of their children."* A presidential campaign is concluding and our two major parties have disagreed about what it takes to raise a child — the Democrats standing behind Hillary Clinton's belief that it takes a village, the Republicans saying it takes a family. This national political discussion of how much power families should have is new. As recently as 1900, leaders of both parties were declaring that questions of how children are raised are not the business of the federal government. What has changed?

Since 1900, we have changed the paths, choices and safeguards that are open to children as they move toward adulthood. In so doing, we have diminished parental sovereignty by creating services and institutions that share with parents the responsibility for the care and protection of the young. We have elongated the period of parental responsibility by lengthening the period of time it takes children to reach freestanding maturity. Elementary education has become free and compulsory for all children. Most go on to secondary education and college. Institutions offering care, protection and education to distressed or handicapped children have proliferated in great variety and number. Parents now find themselves surrounded by a small army of "whole-child professionals." Teachers, social workers, pediatricians, remedial reading teachers, guidance counselors, teachers of the blind and child psychiatrists offer essential support and guidance and expect reasonable cooperation.

We do not have, I believe, a complete set of intellectual tools to think about what 20th-century parents need and the problems they face. We hold to the belief that good parenting requires skills of the hands, the head or the heart. Good parenting requires all those skills in abundance. But most good parents, as their children grow up, find that their skills and capacities are called upon in other ways as their children find their way through the thousands of behavior settings of a modern community. Parents find themselves serving as guides, consultants, coaches, mediators, negotiators, spiritual advisers, vocational counselors and financiers.

Developmental psychologists have traditionally promoted good parenting by communicating norms, by efforts to foster good emotional relationships or by efforts to find the traits of good parents. Arnold Gesell's classic descriptions of the motoric activities, attitudes and personality characteristics of "Twos" and "Fives" is the classic of the norms-centered approach. Today, writers such as Spock and Brazelton help parents calibrate their experiences against those of other parents. The emotion-centered approach to parenting comes from several generations of psychoanalytic writers. Characteristically, these writers have emphasized the need for a positive emotional relationship between parents and their children as a foundation for positive human development. We have another literature trying to capture the traits of good or bad parents — growing more complex as it is recognized that parents do not act in the same way with all their children, and as we move away from the assumption that in socialization the parent is always Cause and the child is always Effect.

We need to look at the social and political relations in which the parenting role is embedded. Parenting occurs in an everyday world in which a variety of professionals and institutions play a role in children's education. Parents maintain a home for the child and within the home have responsibilities for "domestic relations" and "foreign relations."

Our lack of a complete set of intellectual tools with which to think about parenting sets limiting conditions, I believe, in our work with disadvantaged families and their children. Academics, living where we do, do not see the poor and the lives they lead very clearly. Thus, we have had a distressing tendency to throw concepts and attributions at them. The literature on disadvantaged families and children is replete with speculative characterizations: *lack of imaginative capacity, low need for achievement, a sense of external control, high anxiety about school, low vocational and educational aspirations, low self-esteem or self-concept, short attention span, low aggression, less acute visual and auditory perception, a short time perspective, a fatalistic attitude, a low sense of power, little ability to delay gratification, a restricted language code, little ability to use language for communication, little ability to speak decontextually, a low IQ, low school achievement, low conceptual ability or a non-analytic cognitive style.*

In 1996, we have no reason to believe that most poor people are not up to the responsibilities of parenthood. We do have to ask whether poor parents have the knowledge, time and sense of efficacy it takes to play the social and political roles parents have to play in a modern society. ■

Sheldon H. White, PhD is professor of psychology at Harvard University.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Families in Society

Basing policy reform on family values is unwise

By Cynthia Garcia Coll, PhD

As observers of popular culture in the United States, we can trace the origin of the current debate over family values to Dan Quayle's notorious family values speech given during the 1992 presidential campaign, during which he attacked TV's fictional single mother Murphy Brown.

The speech was about the current "poverty of family values" and denigration both of fathers and the importance of fathers in their children's lives. The specific statement was: "It doesn't help matters when prime-time TV has Murphy Brown — a character who supposedly epitomizes today's intelligent, highly paid, professional woman — mocking the importance of fathers by bearing a child alone and calling it just another 'lifestyle choice.'"

Blaming all of society's problems on one aspect of human activity is an oversimplification that can ultimately be dangerous.

The argument was and remains that society's problems are due to a decline in family values. The daily reports of urban fears, high divorce rates and increases in crime, teenage sexual activity, the number of high school dropouts as well as children suffering from abuse and neglect are all blamed on families not espousing traditional family values. The current lack of family values, coupled with an emphasis on personal responsibility, also serves as the basis for many of the social policy reforms, like welfare reform, that are in the process of being ratified and implemented by our gov-

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It's up to states to soften the blow of the new welfare reform law, a report says.
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Research supports what play therapists have known all along: Preschoolers who show distress and destructive themes in their play are at risk for behavior problems later on.
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Kids who see these doctors don't get a lollipop at their appointments; they get something more lasting.
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This month's client handout

Toy safety tips for the holidays

Assessment

Pediatricians: Brazelton Scale opens communication with parents

An infant behavior assessment scale that until recently was restricted to academic and research settings is being taught to pediatricians and other clinicians, in the hope that it will start meaningful discussions with parents about their baby's development.

The Neonatal Behavioral Assessment Scale (NBAS), developed by pediatrician T. Berry Brazelton, MD, measures a newborn baby's responses by comparing them to responses of other babies, starting at birth and continuing, in three-hour increments, through the first two weeks of life.

Brazelton, who established the Child Development Unit at Children's Hospital in Boston, says the idea is to help new parents get to know their babies better. "There are certain times when people are particularly vulnerable, and because of their vulnerability, they're wide open to what we can offer them," Brazelton told a group at the annual convention of the American Academy of Pediatrics in Boston in October. "And if we're there to offer it to them, they feel reinforced. If we're not, they feel the danger of failure is wide open."

Professionals who offer parents education and encouragement at

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Public Policy

Report calls for protection of children in welfare redesign

It will be up to officials in the states to ensure that the recently enacted welfare reform law does not create a domino effect that topples states' entire network of social service programs, leaving children with behavioral health problems without the services they need.

So concludes the draft of a comprehensive analysis of this year's controversial federal changes to the welfare program. The report from the Judge David L. Bazelon Center for Mental Health Law focuses on the new law's effects on children with serious emotional disturbance and their families, with an emphasis on the impact of the transition to state-run welfare systems and a change in the assessment criteria for determining children's eligibility for Supplemental Security Income (SSI).

The report's bottom line is this: Officials from a variety of state agencies will have to coordinate their planning efforts to guarantee that families slated to lose federal benefits have alternative sources of help.

"States have a number of opportunities to ease the impact of some of the law's provisions and to create beneficial outcomes for families and children," according to the report, titled "An Uncertain Future: How the New Welfare Law Affects Children with Serious Emotional Disturbance and Their Families."

While the congressional debate over changing the Aid to Families with Dependent Children (AFDC) program focused on the issue of moving welfare recipients to work, the 50-page report from the Bazelon Center clearly illustrates how closely are connected the programs that make up the social-service safety net.

For example, families whose children will lose SSI benefits because of the elimination of the Individualized Functional Assessment (IFA) as the vehicle for determining eligibility are likely to turn to the new state welfare program (Temporary Assistance for Needy Families) or the child protection system for help. But in many states, these areas are underfunded, even for current caseloads, the report states.

The element of the welfare law that has received the most attention in the mental health field is its changes to the SSI program. An estimated 315,000 children are at risk of losing benefits because of changes in eligibility standards that emphasize medical criteria and diminish the importance of maladaptive behavior in determining childhood disability.

No new beneficiaries will be accepted under the IFA criteria, and current beneficiaries who qualified under that assessment will be reviewed under the new criteria, though all will continue to receive benefits until at least July 1, 1997. Of the current beneficiaries who qualified under the IFA, 44 percent have a mental illness or serious emotional disorder.

The Social Security Administration has published interim regu-

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lations specifying how the new definition of childhood disability will be implemented. But the Bazelon report states that long before these regulations are finalized, state officials can take steps to mitigate the loss of SSI benefits and allow families to continue to take care of their children at home:

- ✓ Ensure that children with serious emotional disturbance qualify for other forms of cash aid, such as state welfare benefits.
- ✓ Protect these children under various Medicaid categories so their families do not automatically lose Medicaid coverage when the children are dropped from SSI. Also, the report urges states to cover services such as therapeutic foster care, crisis services and family support under Medicaid.
- ✓ Identify ahead of time the number of children who stand to lose benefits under the new criteria, so that states can develop proactive strategies to offer alternative aid.

In the area of welfare policy, the report suggests that states take advantage of the broad discretion the federal government has granted to them and:

- ✓ Resist any move to lower the new federally designated time limit of five years on welfare benefits, and waive the five-year limit entirely for victims of domestic violence and for parents who have children with disabilities.
- ✓ Help young mothers, including those with mental health problems, by finding them alternate living arrangements if it is determined that they cannot live safely at home.
- ✓ Exempt families raising children with serious emotional disturbance or other disabilities as "hardship" cases from the welfare programs' requirements.

More than half of the states already have submitted to Washington their plans for complying with the new law, well in advance of the July 1 deadline. One mental health advocate suspects that most of the plans submitted thus far lack the kind of program coordination the Bazelon Center seeks.

"I don't have a lot of faith that a lot of states are doing much planning across agencies," says Barbara Huff, executive director of the Federation of Families for Children's Mental Health. ■

Reprinted from the Nov. 18 issue of *Mental Health Weekly*. You can reach the David L. Bazelon Center for Mental Health Law at (202) 467-5730.

Keep Your Eye On

... family structure and drug use.

Adolescents have a better chance of staying away from illegal drug use if they are living with two biological or adoptive parents, according to a study by the U.S. Department of Health and Human Services (HHS). The study finding was consistent across a broad range of variables, including gender, age, family income and race.

HHS Secretary Donna Shalala says this is the first time the agency has examined the relationship between family structure and adolescent substance abuse. Previous studies have examined the effects of family structure on alcohol and cigarette use among youths, as well as on the risk of teenage pregnancy.

The study found:

- Adolescents not living with two biological or adoptive parents are 50 to 150 percent more likely to use illegal substances and need treatment than those who live under such a structure.
- The family structure that presents the highest risk for adolescent drug abuse is a biological father and a stepmother. The next most dangerous structure is a married adolescent living with his or her spouse, followed by a father and no mother, and a mother living with a non-relative.
- Risk of adolescent drug use is higher with a biological father and a stepmother than with a biological mother and a stepfather. It's also higher with a biological father and no mother figure than with a biological mother and no father figure.

The study used data from about 22,000 respondents ages 12 to 17 in the combined 1991-93 National Household Surveys on Drug Abuse.

... early signs of schizophrenia.

Some teenagers who withdraw from friends and start getting low grades at school could be showing early symptoms of schizophrenia, according to an expert who addressed the World Congress of Psychiatry in Spain last fall. Patrick McGorry, of the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia, told attendees, "Often, the more non-specific things you do see in adolescence can be the very first signs of psychotic illness." The EPPIC is trying to educate general practitioners and school counselors to recognize warning signs so youths can be helped before they develop psychotic symptoms. Teenagers who have had no previous problems and suddenly become withdrawn are among those who should be referred.

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What's New in Research

Can preschoolers' play predict behavior problems?

Children who display more distress and destructive themes in their play have more externalizing behavior problems, as rated by their parents and teachers, according to a recent study. The findings offer the first empirical validation of the link between representations of the preschooler's internal state and measurable, external difficulties. Researchers videotaped 51 healthy children — 25 boys and 26 girls — at play at 41, 55 and 66 months of age. They coded each child's emotions and the theme of his or her play while he or she acted out stories about a variety of topics, such as losing a pet dog, spilling juice or solving dilemmas, such as whether to get a bandage for a younger sibling after mom has said not to touch anything on the bathroom shelf. Distress and aggressive and destructive themes expressed by the children at ages 4 and 5 were significantly correlated with their externalizing scores tallied by their parents on the Child Behavior Checklist and, for the 5-year-olds, by their teachers on the Teacher's Report Form. This association did not hold true when the children were 3, possibly because of developmental differences, say the researchers. Nor was there a relationship between behavior problems and the negative emotions of anger, concern and sadness. The researchers posit that showing these emotions may be appropriate in the context of telling stories, but the display of distress is more extreme and may reflect emotional dysregulation.

"Can emotions and themes in children's play predict behavior problems?" Susan L. Warren, MD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10):1331-1337, 1996. For reprints, write to Dr. Warren, University of Minnesota, Box 95 UMHC, 420 Delaware St. SE, Minneapolis, MN 55455.

Hyperactive children may have less obvious problems

Hyperactive children may have other problems, including internalizing symptoms, that may not be as salient as the externalizing problems that often bring children for evaluation. That's the main finding of a study of 246 children ages 6 to 11 evaluated at a general outpatient child psychiatry clinic and at a specialty attention-deficit disorder program. Although previous studies have shown that boys have much higher rates of antisocial behavior and conduct problems, the pattern of comorbidity in the children was about the same in girls as it was in boys. The more hyperactive the child, as measured by the Child Behavior Checklist, the more likely he or she was to have internalizing and externalizing disturbances. This finding suggests that comorbidity reflects the severity of the hyperactivity.

"Comorbidity in hyperactive children: issues related to selection bias, gender, severity and internalizing symptoms," Stewart Gabel, MD, et al., *Child Psychiatry and Human Development*, 27(1):15-28, 1996. For reprints, write to Dr. Gabel, Department of Psychiatry and Behavioral Sciences, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218-1088.

Parents can influence move's effects on children

The disruption of children's lives brought on when a family moves can have negative effects that extend into early adulthood, but these effects may be mediated by parents' involvement, according to a study of a rapidly growing suburb of Toronto. Adolescents who had moved to the Toronto area were significantly less likely to finish high school or college, and more likely to have lower occupational status, than were peers who had lived there all their lives. The study was based on follow-up interviews with 492 young adults who had participated in the first stage of a life course study in 1976, when they were adolescents. Among those who moved, adolescents who said that their mother was supportive and that their father participated in the family fared best. Conversely, the negative effects of moving were significantly more pronounced in families with unsupportive mothers and uninvolved fathers.

"New kid in town: social capital and the life course effects of family migration on children," John Hagan, et al., *American Sociological Review*, 61(3):368-385, 1996. For reprints, write to Dr. Hagan, Department of Sociology, University of North Carolina at Chapel Hill, 155 Hamilton Hall, CB#3210, Chapel Hill, NC 27599-3210, or send e-mail to jhagan@email.unc.edu.

Cigarette advertising linked to smoking behavior

Young adolescents' exposure to cigarette marketing was significantly related to their self-reported smoking behavior, even when the influence of friends and family was controlled for, according to a survey of 571 ethnically and socioeconomically diverse seventh-graders. In fact, cigarette marketing turned out to be a more powerful predictor of their experimentation with cigarettes than having parents who smoked. Students who saw cigarette advertisements in magazines were 21 percent more likely to experiment with smoking than those who said they hardly ever or never saw ads. And kids see a lot of cigarette advertising: 88 percent of these 13-year-olds reported exposure to cigarette marketing.

"Seventh graders' self-reported exposure to cigarette marketing and its relationship to their smoking behavior," Caroline Schooler, PhD, et al., *American Journal of Public Health*, 86(9):1216-1221, 1996. For reprints, write to Dr. Schooler, Stanford Center for Research in Disease Prevention, Stanford University School of Medicine, 1000 Welch Road, Palo Alto, CA 94304-1825.

Brown University Child & Adolescent Behavior Letter
1996 Book Notices

Editor's Note: The number of books received in the editorial offices has quite outstripped our capacity for extensive commentary. Nonetheless, we believe the following volumes will be found to be especially noteworthy. These books may be purchased or ordered from your favorite bookstore.

A Comprehensive Guide to Attention Deficit Disorder in Adults: Research, Diagnosis, Treatment — K.G. Nadeau, Brunner/Mazel, 1995, 426 pages, $38.95 (hard).

Give Sorrow Words: Working with a Dying Child — D. Judd, Haworth Press, 1995, 242 pages, $24.95 (soft).

Reflections on Violence — J. Keane, Verso (London), 1996, 200 pages, $17.95 (soft).

Coping with Children's Temperament: A Guide for Professionals — W.B. Carey and S.C. McDevitt, Basic Books, 1995, 235 pages, $35 (hard).

When Love is Not Enough: The Management of Covert Dynamics in Organizations that Treat Children and Adolescents — D. Piazza, Ed., Haworth Press, 1996, 105 pages, $24.95 (hard).

Psychology: The Hope of a Science — G.A. Kimble, MIT Press, 1995, 153 pages, $25 (hard).

Children and Grief: When a Parent Dies — J.W. Worden, Guilford Press, 1996, 225 pages, $26.95 (hard).

Feminism and Sexuality: A Reader — S. Jackson and S. Scott, Eds., Columbia University Press, 1996, 390 pages, $16.50 (paper).

Ethical Issues in Mental Health Research with Children and Adolescents — K. Hoagwood, P. Jensen and C. Fisher, Eds., Lawrence Erlbaum Associates, 1996, 320 pages, $47.95 (hard), $19.60 (soft).

Missing Children: A Psychological Approach to Understanding the Causes and Consequences of Stranger and Non-Stranger Abduction of Children — J.N. Tedisco and M.A. Paludi, SUNY Press, 1996, 182 pages, $59.50 (hard), $19.95 (soft).

The Handbook of Infant, Child, and Adolescent Therapy (Vol. 1): A Guide to Diagnosis and Treatment — B.S. Mark and J.A. Incorvaia, Eds., Jason Aronson, 1995, 438 pages, $50 (hard).

Learning the Rules: The Anatomy of Children's Relationships — B.J. Bigelow, G. Tesson and J.H. Lewko, Guilford Press, 1996, 255 pages, $35 (hard).

Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society — B.A. van der Kolk, A.C. MacFarlane and L. Weisaeth, Eds., Guilford Press, 1996, 596 pages, $55 (hard).

Diseasing of America: How We Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control — S. Peele, Lexington Books, 1995 (reissue, with new preface, of a 1989 volume), 321 pages, $14.95 (soft).

Foundations of Animal Behavior: Classic Papers and Commentaries — L.D. Houck and L.C. Drickamer, Eds., University of Chicago Press, 1996, 842 pages, $95 (hard), $34.95 (soft).

Children with Prenatal Drug Exposure — L.S. Chandler and S.J. Lane, Eds., Haworth Press, 1996, 199 pages, $29.95 (hard).

Japanese Childrearing: Two Generations of Scholarship — D.W. Schwalb and B.J. Schwalb, Eds., Guilford Press, 1996, 323 pages, $45 (hard).

Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures — F. Shapiro, Guilford Press, 1995, 398 pages, $42 (hard).

Beyond Burnout: Helping Teachers, Nurses, Therapists and Lawyers Recover from Stress and Disillusionment — C. Cherniss, Routledge, 1995, 234 pages, $55 (hard), $17.95 (soft).

Human Attachment — V.L. Colin, McGraw-Hill, 1996, 377 pages, $15 (soft).

Children, Families and Government: Preparing for the Twenty-first Century — E.F. Zigler, S.L. Kagan and N.W. Hall, Eds., Cambridge University Press, 1996, 439 pages, $69.95 (hard), $24.95 (soft).

Contemporary Intellectual Assessment: Theories, Tests, and Issues — D.P. Flanagan, J.L. Genshaft and P.L. Harrison, Eds., Guilford Press, 1996, 575 pages, $60 (hard).

Child Care and Culture: Lessons from Africa — R.A. LeVine, S. Dixon, S. LeVine, A. Richman, P.H. Leiderman, C.H. Keefer and T.B. Brazelton, Cambridge University Press, 1996, 346 pages, $49.95 (hard), $21.95 (soft).

Child Psychopathology — E.J. Mash and R.A. Barkley, Eds., Guilford Press, 1996, 601 pages, $65 (hard).

The History of Childhood — L. DeMause, Ed., Jason Aronson, 1995, 450 pages, $40 (republished in softcover).

"Crazy" Therapies: What Are They? Do They Work? — M.T. Singer and J. Lalich, Jossey-Bass, 1996, 263 pages, $23 (hard).

Skills Training for Children with Behavior Disorders: A Parent and Therapist Guidebook — M. L. Bloomquist, Guilford Press, 1996, 273 pages, $29.95 (paper).

The Custody Evaluation Handbook: Research-based Solutions and Applications — B. Bricklin, Brunner/Mazel, 1995, 300 pages, $45.95 (paper).

Family Violence Across the Lifespan — O.W. Barnett, C.L. Miller-Perrin and R.D. Perrin, Sage, 1997, 392 pages, $32.95 (soft).

Residential Education as an Option for At-Risk Youth — J. Beker and D. Magnuson, Eds., Haworth Press, 1996, 133 pages, $24.95 (hard).

Treating Abused Adolescents — E. Gil, Guilford Press, 1996, 228 pages, $18.95 (soft).

The Five to Seven Year Shift: The Age of Reason and Responsibility — A.J. Sameroff and M.M. Haith, Eds., University of Chicago Press, 1996, 484 pages, $39.95 (hard).

Change Processes in Psychotherapy: Revitalizing Treatment and Research — S.R. Shirk and R.L. Russell, Guilford Press, 1996, 395 pages, $38.95 (hard).

The Emotional Needs of Young Children and Their Families: Using Psychoanalytical Ideas in the Community — J. Trowell and M. Bower, Routledge, 1996, 299 pages, $69.95 (hard), $19.95 (soft).

Temperament: Theory and Practice — S. Chess and A. Thomas, Brunner/Mazel, 1996, 224 pages, $24.95 (soft).

Sexual Abuse and Eating Disorders — M.F. Schwartz and L. Cohn, Eds., Brunner/Mazel, 1996, 240 pages, $27.95 (hard).

Emerging School-Based Approaches for Children with Emotional and Behavioral Problems: Research and Practice in Service Integration — R.J. Illback and C.M. Nelson, Eds., Haworth Press, 1996, 249 pages, $49.95 (hard).

Feral Children and Clever Animals: Reflections on Human Nature — D.K. Candland, Oxford University Press, 1993, 411 pages, $16.95 (soft).

Brazelton Scale

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these critical junctures, which Brazelton calls "touchpoints," go a long way toward helping them cement a healthy relationship with their child. This becomes even more important for babies at risk of developmental delays.

"What parent would ever think of the baby's internal feedback system if she was worried about her baby's jitteriness, jumpiness — which is what we're seeing now with these crack- and cocaine-addicted mothers," says Brazelton, author of 26 books on pediatrics and child development. "They're so overwhelmed and frightened that of course they're going to overlook these hypersensitive, hyperreactive babies. If we're there to model some of these reactions, we can pick up on the energy that's there for attachment and bring it back to their focus."

The symposium, sponsored by Johnson & Johnson, marked one of the first times the NBAS has been taught to pediatricians in this country. None of the professionals in attendance disputed the importance of behavioral assessments, but a few complained about a lack of time. Constance H. Keefer, MD, director of clinical programs at the Brazelton Institute, says behavioral assessments can be integrated into a regular physical exam.

"Perhaps a pediatrician has 15 minutes with a newborn," Keefer says. "I want you to get a sense of how powerful those 15 or 20 minutes become when the pediatrician is in the presence of the parents. On top of that, while you are handling a newborn, you actually can see displayed almost inadvertently most of the newborn behavior defined on the Brazelton Scale."

For example, a pediatrician can observe how the baby regulates his or her state — one of the items on the scale — in the process of the exam. "I'm watching for how the infant can habituate while asleep to my touch, and then I'm making a note, 'This is a baby who wakes up screaming,'" Keefer says. "Once the infant has screamed, I actually don't immediately act to stop it. Sometimes the infant will console herself by some movements and brushing of the face with the hand. I always want to give an opportunity to see what the infant can do herself."

Keefer stresses that a doctor's appointment is a precious learning opportunity that can demystify the newborn for parents. "I am so impressed with what parents don't know about infants," says Keefer, who is also director of clinical services at Children's Hospital. "I think it's the mysteriousness of the infant's body and behavior that can take a vulnerable parent in the moment of crisis into disorganization in parenting through lack of confidence or feeling incompetent. But by giving them the vocabulary, a vision of the infant, you can be part of moving that crisis resolution in a more positive direction." ■

The third edition of the Neonatal Behavioral Assessment Scale Manual costs $35; the NBAS testing kit costs $50. For order forms or more information, contact the Brazelton Center for Infants and Parents at Children's Hospital, 1295 Boylston St., Suite 320, Boston, MA 02215, or call (617) 355-4959.

Guide eases assessment process for young children

A new guide published by Zero to Three: National Center for Infants, Toddlers and Families promotes a comprehensive approach to assessment that builds on young children's strengths and capabilities, not deficits. Written in collaboration with parents, *New Visions for the Developmental Assessment of Infants and Young Children* also encourages more accurate understanding of how children manage the challenges of everyday life in relation to their families, communities and culture, says Emily Fenichel, associate director of Zero to Three, a training and education center on the development of babies and young children.

Among the guide's recommendations:

- Young children should never be separated from their parents or caregivers during the assessment. Children should not be expected to perform tests well when they are anxious about being separated from their parents.
- Formal tests or tools should not be the cornerstone of the assessment of an infant or young child. Most standardized tests are not designed to bring out the unique abilities of children with atypical or challenging developmental patterns. Misleading scores from these tests can lead to inappropriate services. Structured tests should be only one piece of an integrated approach.
- Assessments limited to areas that are easily measurable should not be considered complete. Measures of motor or cognitive skills are not an accurate picture of the child's developmental capabilities. A complete assessment should reflect a parent's experience with a child and include independent observations of a child's interaction with the parent. ■

New Visions for the Developmental Assessment of Infants and Young Children is available for $35, plus $4 for shipping and handling, by contacting Zero to Three: National Center for Infants, Toddlers and Families, 734 15th St. NW, Suite 1000, Washington, DC 20005-1013, or calling (800) 899-4301.

Family values

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ernment. The rationale goes like this: Why should we support promiscuous, unproductive or even lazy individuals and their children?

There are serious problems with the logic behind these assertions, as well as a lack of evidence to support them. To place the blame for today's societal problems on one single institution — the family — and on only one aspect of family functioning — values — is misguided. It negates the reality of family life in a complex society and dismisses many sources of evidence that indicate family values are not the source of our many problems.

My argument is not that family values are not important in our society, or that we cannot find examples of families we wished were more invested in their children's well-being. But blaming all of society's problems on one aspect of human activity is an oversimplification that can ultimately be dangerous.

So, are family values declining?

I have been conducting research with so-called "at-risk" families for the last 20 years and have concluded that there are very few at-risk individuals but many, many at-risk environments and circumstances.

I have documented the experiences of teenage mothers in contexts that are supportive of their special circumstances and needs, and have found that, given promoting circumstances, teenage mothers have had the same developmental outcomes as older mothers. I have observed many reasons and circumstances that contribute to teenage pregnancies and many consequences, both good and bad, for the mothers and their children. What I have been most impressed by is how the circumstances around the pregnancy and the family life after the birth are much more important in determining the outcome than the mother's previous hopes or dreams.

Why do some family systems survive and others collapse when confronted with similar demands? A very complex answer comes to mind of both internal and external resources and circumstances. A simple decline in family values is not an adequate explanation.

This conclusion is even more evident in a recent study of women who participated in a focus group and interviews that actually were designed for a purpose other than to learn about their "family values." The women were all in a low-security prison in central Massachusetts. They were relatively young, mostly in their 20s and 30s; 82 percent of them were mothers; a lot of them were high school graduates. For the most part they were incarcerated for drug-related crimes and were serving up to 15-year sentences.

The following are spontaneous statements within their discussions of other related topics. This is important to keep in mind, because they chose to bring up family values in their discussions, and were not prompted to do so by us or by the questions we asked.

One of the questions we asked was: Why do women end up in

Remembering a gifted colleague

Ferdinand Jones, PhD, and Carol Landau, PhD

It was a year ago, on Dec. 20, 1995, that the Brown University community suffered a tragic loss. The American Airlines crash in Colombia took with it our dear friend and colleague, Dr. Maria-Teresa Otoya. She and her husband, computer science professor Paris Kannelakis, and their children, Alexandra and Stephanos, were traveling to Calí, to visit the Otoya family for Christmas. We continue to feel sad, and our thoughts turn to them, especially at this time, anniversary time.

Both of us were fortunate enough to have worked with Dr. Otoya. We remember Maria-Teresa's warmth, her sense of humor, her smile and her passionate commitment to her clients. But what we remember most about Maria-Teresa is the feeling of validation experienced whenever we spent time with her. It was a gift. Maria-Teresa could understand you and identify your unique best qualities. She then nurtured these qualities so that you could grow. It was this gift that made her an effective psychotherapist, a loving wife, a supportive friend and an exceptional parent.

When we think of Maria-Teresa and Paris as a couple, we remember their values. They believed in hard work. They were devoted to family — to Alexandra and Stephanos, of course, and to their families in Colombia and Greece. Education was at the center of their lives.

It was therefore most fitting that the first lecture in the series established by Brown's Psychological Services and Office of Student Life in memory of Dr. Otoya should be presented by her good friend, professor of education Cynthia Garcia Coll. ■

Ferdinand Jones, PhD, is a professor of psychology at Brown University and former director of the university's Psychological Services. Carol Landau, PhD, is a clinical professor of psychiatry and human behavior, and a psychotherapist at Rhode Island Hospital. Both are members of the editorial advisory board of *The Brown University Child and Adolescent Behavior Letter*.

Toy Safety Tips for the Holidays

The matching game

- Toys should be matched to a child's abilities. The manufacturer recommendations serve as a useful guide. A toy that is too advanced or too simple for a child may be misused, which can lead to injury.
- Think BIG when choosing toys. All toy parts should be larger than the child's mouth to prevent injuries, including choking.
- Never buy hobby kits, such as chemistry sets, for any child younger than 12 years old.

Purchasing tips

- Before buying a toy, read the instructions. If the toy is appropriate for the child, read the instructions to the child for proper use of the toy.
- To avoid risk of serious eye or ear injury, avoid toys that shoot small objects into the air or make loud or shrill noises. Parents can hold the noise-making toy next to their ear to determine whether it will be too loud for a child's ears.
- Look for sturdy toy construction. The eyes, nose and other small parts on soft toys and stuffed animals should be securely fastened on the toy. In addition, avoid toys with sharp edges.
- Tips of arrows or darts should be blunt, made of soft rubber or flexible plastic and securely fastened to the shaft.

Guidelines for choosing age-appropriate toys

The following is a list that the American Academy of Pediatrics recommends for specific age groups. Use these recommendations when choosing toys. However, always remember that these are merely guidelines; parents should continue to watch out for mislabeled toys and should always provide proper supervision for younger children.

Newborn to 1-year-old baby

Choose eye-catching toys that appeal to your baby's senses of sight, hearing and touch.

- Large blocks of wood or plastic
- Pots and pans
- Rattles
- Soft, washable animals, dolls or balls
- Bright, moveable objects that are out of baby's reach
- Busy-boards
- Floating bath toys
- Squeeze toys

1- to 2-year-old toddler

Toys for this age group should be safe and be able to withstand a toddler's curious nature.

- Cloth or plastic books with large pictures
- Sturdy dolls
- Kiddy cars
- Musical tops
- Nesting blocks
- Push-and-pull toys (Remember: No long strings)
- Stacking toys
- Toy telephones

2- to 5-year-old preschooler

Toys for this age group are usually experimental and should imitate the activity of parents and older children.

- Books (short stories or action stories)
- Blackboard and chalk
- Building blocks
- Crayons, non-toxic finger paints or clay
- Hammer and bench
- Housekeeping toys
- Outdoor toys: Sandbox (with a lid), slide, swing or playhouse
- Transportation toys (tricycles, cars or wagons)

- Tape or record player
- Simple puzzles with large pieces
- Dress-up clothes
- Tea-party utensils

5- to 9-year-old child

Toys for this age group should help your child promote skill development and creativity.

- Blunt scissors, sewing sets
- Card games
- Doctor and nurse kits
- Hand puppets
- Balls
- Bicycles
- Crafts
- Electric trains
- Paper dolls
- Jump ropes
- Roller skates
- Sports equipment
- Table games

For a brochure on toy safety, which includes a list of age-appropriate toys for newborns to 14-year-olds, parents can send a self-addressed stamped envelope to the American Academy of Pediatrics, Publications, PO Box 927, Elk Grove Village, IL 60009-0927. Ask for the toy safety brochure.

10- to 14-year-old child

Hobbies and scientific activities are ideal for this age group.

- Computer games
- Sewing, knitting and needlework
- Microscopes and telescopes
- Table and board games
- Sports equipment
- Hobby collections

The Brown University Child and Adolescent Behavior Letter

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prison? Here are some of the responses we heard that illustrate these women's family values:

- "I thought I needed more than that (money received from a regular job in a nursing home) because I did a lot of things with my kids ...They have been all over."
- "Their husbands lost their jobs ... They sat down and actually planned that drugs could be the thing that could pull them out of the hole ... and they planned to do it just for a little while."
- "Just an economic reason ... they did have houses ... all these bills — furniture, the kids — they thought they could pick up an ounce ... or a kilo ... and sell it and it would be over ... Got caught, and that's how it goes."
- "DSS (takes) their children away ... Once (they) take the kids away ... leaves you no options ... You go out there with hostility. I had no charges when DSS took my kids away ... I went nuts! I sold blatantly ... I did not care ... I consumed as many drugs as I could, sold as many as I could, just so I did not feel that pain, you know, 'cause they took everything away."

From these quotes we can see that to a certain extent having the "right" values got some of these women into trouble.

These women's own perceptions were that their criminal behaviors were not chosen paths, but reactions to economic pressures and other negative circumstances in their lives, perhaps even fueled by their wishes to take care of and provide for their children.

Another part of the argument is that a lack of family values in families of origin leads to criminal and legal behavior. Did these women's families fail to instill in them the right values? A representative comment from them — "My mother ... advised me along the good paths. She always raised me in the religion. When I got married, I took another course. She gave me good advice." — illustrates that from these women's perspectives, some of their families of origin were at least trying to instill in them the "right" values.

Finally, what kinds of values do these women want to teach their own children? Are they aware of the important influence they exert in their children's lives? Again, let's listen to a representative statement: "I believe that a lot of the things... we learn at home ... I tell my daughter ... this is why I am here (the crime that I committed) ... It's not that I can't take responsibility for my crime because I was an addict ... that's a cop-out ... I tell my daughter right up front, because I do not want her thinking that oh yeah, when she reaches an age, she can just go out and commit armed robbery and get what she wants, like I did, because that's wrong. I do not want her thinking that way."

When asked what they looked forward to most when they got out of prison, the women responded that it was being with their children.

It is striking to hear these women's love for their children, their care, their hopes, their fears and their longings. When asked what they looked forward to most when they got out of prison, they responded that it was being with their children.

There is no evidence in these women's references to family values that they were not or are not invested in their children or family life. On the contrary, their children were a source of strength for these women and helped them cope with their situation.

What are the real problems of today's families?

In my analysis, the primary — though not sole — reason for these alarming statistics is that many outside pressures make it difficult, if not impossible, for families to succeed. Thus, the real problems are the outside pressures that families have to contend with and that are insurmountable for many.

We can spend our time blaming and condemning individual families, absent fathers, single mothers, teenage mothers and other mothers and families that do not conform to our ideal, or we can use our time more constructively — to understand why alternative family structures are becoming more the norm than the exception, and how to support "good" family values within these new structures.

But having a new ideal of the functional family is not enough. We have to also create new pressures on families — positive pressures — that spur families to develop. And thus, as a society we need to value and support creativity and resourcefulness in family life. Our economic system as well as our dominant institutions need to join in supporting family life in a changing world. Perhaps when we create a Nobel Prize for creative family life — not superheroes, but creativity — only then will we be on the right track. ■

Cynthia Garcia Coll is professor and chair of the education department, professor of psychology and pediatrics, and associate director of the Center for the Study of Human Development at Brown University. This commentary was excerpted from her presentation at the inaugural Maria Teresa Otoya Memorial Lecture and previously appeared in the university's *George Street Journal*.

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Commentary

Reading as a pediatric intervention: A good dose of books

By Carol Lewis, MD

Since 1993 — the same year the U.S. Department of Education reported that more than two-thirds of American children read below their grade level — a group of pediatricians, educators and interested volunteers at Hasbro Children's Hospital in Providence, RI, has worked to address this problem through research and service projects.

A consensus statement from the National Institute of Education declares that reading aloud to children is the single most important activity in which parents can engage to build the knowledge needed to prepare children to read. However, the simple act of reading to a child may be overwhelming for many of the parents who take their children to the Hasbro Pediatric Clinic because of limited resources and lack of confidence in their own reading ability. The Read to Me program is designed to improve the situation.

Three primary goals of the Read to Me program are to: foster an interest in reading for children; increase parent awareness of the importance of reading aloud to their children; and provide an opportunity for the pediatrician to stress the importance of reading in the overall health and well-being of a child.

> *There is a demonstrable multifold increase in parents' reading to their children in low-income families when pediatricians supply developmentally appropriate books at well-child visits.*

The family's introduction to the program begins in the pediatric clinic waiting area where a diverse group of hospital volunteers choose developmentally appropriate books to read aloud to children while they are waiting for their appointments. The response from children and their parents has been enthusiastic. Little children cluster around volunteers, eager to hear stories unfold. Even older siblings get involved, reading to younger siblings.

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When the family sees the pediatrician, he or she encourages parents to read aloud to their children and tells them how beneficial reading can be to school readiness, language development and bedtime struggles. The message is reinforced at every clinic visit when the doctor gives the child a new book to take home.

There is a demonstrable multifold increase in parents' reading to their children in low-income families when pediatricians supply developmentally appropriate books at well-child visits. It is not unusual to overhear a pediatrician-in-training discuss the importance of reading, along with nutrition, discipline, development and other anticipatory guidelines, when advising a parent. This setting also provides the opportunity to direct those parents unsure of their own reading skills to an appropriate literacy program.

Pediatricians give sturdy children's board books with brightly colored pictures and simple language to every child at each well-child visit beginning when children are 6 months old, continuing through 36 months. Along with each book, parents are given handouts describing the importance of book sharing with young children, what children this age can do with a book, how a parent can enjoy books with a child, and how to share books as part of a regular bedtime routine. The simple intervention doubled low-income parents' reported enjoyment of and participation in child-centered book-related activities. Similar studies are evaluating the effectiveness of literacy-promoting intervention delivered to low-income bilingual families with young children.

It is gratifying to find in our high-tech culture such a simple and inexpensive intervention delivered by a group of pediatricians. Other pediatric programs around the country have become aware of these findings and are introducing similar programs. ■

Carol Lewis is a pediatrician at Rhode Island Hospital and a clinical instructor of pediatrics and adolescent medicine at Brown University Medical School. She is a member of the editorial advisory board of *The Brown University Child and Adolescent Behavior Letter*.

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